DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2002

Indian Health Service

Justification of Estimates for Appropriations Committees

Indian Health Service

Program Level Funding Summary Report

(Dollars in Thousands)

4/5/2001

FILE: O:\DFM\BFP\FY2002\OMB Bush Budget\PRESIDENT'S BUDGET

Sub-Sub-Activity	2000 Actual	2001 Appropriation	2001 Current Estimate	2002 Estimate
SERVICES:				
Hospitals & Health Clinics	1,005,407 1/	1,086,563	1,084,173	1,137,711
Dental Health	80,062	91,219	91,018	95,305
Mental Health	43,245	45,117	45,018	47,142
Alcohol & Substance Abuse	96,824	100,541	130,254 2/	135,005
Contract Health Services	406,756	446,756	445,773	445,776
Total, Clinical Services	1,632,294	1,770,196	1,796,236	1,860,939
Public Health Nursing	34,452	36,194	36,114	37,781
Health Education	9,625	10,085	10,063	10,628
Community Health Reps.	46,380	48,167	48,061	49,789
Immunization AK	1,402	1,474	1,471	1,526
Total, Preventive Health	91,859	95,920	95,709	99,724
Urban Health	27,813	29,909	29,843	29,947
Indian Health Professions	30,491	30,553	30,486	30,565
Tribal Management	2,411	2,411	2,406	2,406
Direct Operation	50,988	53,063	52,946	65,323
Self Governance	9,531	9,825	9,803	9,876
Contract Support Cost	228,781	248,781	248,234	288,234
TOTAL, SERVICES	2,074,168	2,240,658	2,265,663	2,387,014
FACILITIES:				
Maintenance & Improvement	43,433	46,433	46,331	45,331
Sanitation Facilities	92,117	93,823	93,617	93,827
Health Care Facilities Construction	50,393	85,714	85,525	37,568
Facilities & Environmental Health Support	116,282	121,604	121,336	126,775
Equipment	14,330	16,330	16,294	16,294
TOTAL, FACILITIES	316,555	363,904	363,103	319,795
TOTAL, BUDGET AUTHORITY	2,390,723	2,604,562	2,628,766	2,706,809
COLLECTIONS:				
Medicare 3/	109,063	114,728	114,728	135,776
Medicaid 3/	283,277	316,113	316,113	324,249
Private Insurance	39,354	39,960	39,960	39,960
Quarters	4,700	4,700	4,700	4,700
TOTAL, COLLECTION	436,394	475,501	475,501	504,685
ADVANCE TRANSFER APPROPRIATION:				
Diabetes 4/	30,000	30,000	100,000	100,000
TOTAL, PROGRAM LEVEL	2,857,117	3,110,063	3,204,267	3,311,494

1/ FY 2000 appropriation reduced by $5,000 as a result of CFO/CIO transfer.

2/ Includes $30,000,000 in the final FY 2001 Labor/HHS Appropriation.

3/ Includes $29,203,000 in Medicaid/Medicare for tribal collection estimates.

4/ The Balanced Budget Act of 1997 transfers $30,000,000 annually to IHS for diabetes prevention and treatment for FY 1998 through FY 2002. An additional $70,000,000 a year received under the Medicare, Medicaid, and SCHIP Benefits improvement and Protection Act of 2000 for FY 2001 and FY 2002, and $100,000,000 is available in FY 2003.

Indian Health Service

Funding Summary Report by Budget Authority

(Dollars in Thousands)

FILE: O:\DFM\BFPB\FY2002\OMB Bush Budget\PRESIDENT'S BUDGET 3/31/2001

Sub Sub Activity	2000 Enacted	2001 Appropriation	2001 Current Estimate	2002 Estimate
SERVICES:				
Hospitals & Health Clinics	$1,005,407 1/	1,086,563	$1,084,173	$1,137,711
Dental Services	80,062	91,219	91,018	95,305
Mental Health	43,245	45,117	45,018	47,142
Alcohol & Substance Abuse	96,824	100,541	130,254 2/	135,005
Contract Health Services	406,756	446,756	445,773	445,776
Total, Clinical Services	1,632,294	1,770,196	1,796,236	1,860,939
Public Health Nursing	34,452	36,194	36,114	37,781
Health Education	9,625	10,085	10,063	10,628
Comm. Health Reps	46,380	48,167	48,061	49,789
Immunization AK	1,402	1,474	1,471	1,526
Total, Prev Hlth	91,859	95,920	95,709	99,724
Urban Health	27,813	29,909	29,843	29,947
Indian Health Professions	30,491	30,553	30,486	30,565
Tribal Management	2,411	2,411	2,406	2,406
Direct Operation	50,988	53,063	52,946	65,323
Self Governance	9,531	9,825	9,803	9,876
Contract Support Cost	228,781	248,781	248,234	288,234
Total, Services	2,074,168	2,240,658	2,265,663	2,387,014
FACILITIES:				
Maint. & Improvement	43,433	46,433	46,331	45,331
Sanitation Facilities	92,117	93,823	93,617	93,827
Hlth Care Facilities Construction	50,393	85,714	85,525	37,568
Facil. & Envir. Hlth Support	116,282	121,604	121,336	126,775
Equipment	14,330	16,330	16,294	16,294
Total, Facilities	316,555	363,904	363,103	319,795
TOTAL, Budget Authority	$2,390,723	$2,604,562	$2,628,766	$2,706,809

1/ FY 2000 appropriation reduced by $5,000 as a result of CFO/CIO transfer.

2/ Includes $30,000,000 in the final FY 2001 Labor/HHS Appropriation.

Indian Health Service

FY 2002 Budget Request

Detail of Changes

(Dollars in Thousands)

FILE: A:\DETAIL OF CHANGES+20M

4/4/2001

Sub Sub Activity	2001 Appropriation	Non-Recurr Funds	Rate Increase	Pay Cost (3.7% 2001 2002 3.6%Civilian 4.6% Com. Ofc	Inflation: Tribal Pay Cost	Staffing For New Facilities	Contract Support Cost	Federal Cost of Navajo Conversion	Health Care Facilities Construction	Indian Hlth Care Improvement Fund	Information Techology	2002 Estimate
SERVICES:												
Hospitals & Health Clinics	1,084,173	0	0	20,382	13,984	7,172	0	0	0	8,000	4,000	1,137,711
Dental Services	91,018	0	0	2,445	397	1,445	0	0	0	0	0	95,305
Mental Health	45,018	0	0	1,076	514	534	0	0	0	0	0	47,142
Alcohol & Substance Abuse 1/	130,254	0	0	496	4,255	0	0	0	0	0	0	135,005
Contract Health Services	445,773	0	0	3	0	0	0	0	0	0	0	445,776
Total, Clinical Svcs	1,796,236	0	0	24,402	19,150	9,151	0	0	0	8,000	4,000	1,860,939
Public Health Nursing	36,114	0	0	1,004	240	423	0	0	0	0	0	37,781
Health Education	10,063	0	0	136	167	262	0	0	0	0	0	10,628
Comm. Health Reps	48,061	0	0	0	1,728	0	0	0	0	0	0	49,789
Immunization AK	1,471	0	0	2	53	0	0	0	0	0	0	1,526
Total, Prev Hlth	95,709	0	0	1,142	2,188	685	0	0	0	0	0	99,724
Urban Health	29,843	-1,000 4/	0	20	1,084	0	0	0	0	0	0	29,947
Indian Health Professions	30,486	0	0	79	0	0	0	0	0	0	0	30,565
Tribal Management	2,406	0	0	0	0	0	0	0	0	0	0	2,406
Direct Operation	52,946	0	0	1,971	406	0	0	10,000	0	0	0	65,323
Self Governance	9,803	0	0	73	0	0	0	0	0	0	0	9,876
Contract Support Costs	248,234	0	0	0	0	0	40,000 5/	0	0	0	0	288,234
Total, Services	2,265,663	(1,000)	0	27,687	22,828	9,836	40,000	10,000	0	8,000	4,000	2,387,014
FACILITIES:												
Maint. & Improvement	46,331	-1,000 4/	0	0	0	0	0	0	0	0	0	45,331
Sanitation Facilities	93,617	0	0	210	0	0	0	0	0	0	0	93,827
Hlth Care Facs. Constr.	85,525	(85,525)	0	0	0	0	0	0	37,568 7/	0	0	37,568
Facil. & Envir. Hlth Supp	121,336	0	0	4,103	172	1,164	0	0	0	0	0	126,775
Equipment	16,294	0	0	0	0	0	0	0	0	0	0	16,294
Total, Facilities	363,103	(86,525)	0	4,313	172	1,164	0	0	37,568	0	0	319,795
Total, IHS	2,628,766	(87,525)	0	32,000	23,000	11,000 6/	40,000	10,000	37,568	8,000	4,000	2,706,809
COLLECTIONS:												
Medicare 2/	114,728	0	21,048	0	0	0	0	0	0	0	0	135,776
Medicaid 2/	316,113	0	8,136	0	0	0	0	0	0	0	0	324,249
Private Insurance	39,960	0	0	0	0	0	0	0	0	0	0	39,960
Quarters	4,700	0	0	0	0	0	0	0	0	0	0	4,700
TOTAL, COLLECTION	475,501	0	29,184	0	0	0	0	0	0	0	0	504,685
ADVANCE TRANSFER APPROPRIATION:												
Diabetes 3/	100,000	0	0	0	0	0	0	0	0	0	0	100,000
TOTAL, PROGRAM LEVEL	3,204,267	(87,525)	29,184	32,000	23,000	11,000	40,000	10,000	37,568	8,000	4,000	3,311,494

1/ Includes $30,000,000 in the final FY 2001 Labor/HHS Appropriation.

2/ Includes $29,203,000 in Medicaid/Medicare for tribal collection estimates.

3/ The Balanced Budget Act of 1997 transfers $30,000,000 annually to IHS for diabetes prevention and treatment for FY 1998 through FY 2002. An additional $70,000,000 received under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 in FY 2001, FY 2002, and $100,000,000 for FY 2003.

4/ One-Time Projects: Urban Health (SIPI) and Maintenance & Improvement (AMEX).

5/ Increase in Contract Support Cost is for Navajo Contract.

6/ Increase reflects 15 FTE and $1,210,000 for Ft. Defiance, AZ Hospital and 119 FTE and $9,790,000 for Parker, AZ Health Center.

7/ Includes $11,326,000 for equipment for Ft. Defiance, AZ Hospital, $23,241,000 for the completion of the Winnebago, NE Hospital, and $3,001,000 for Ft. Defiance, AZ Quarters.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

FILE: O:\DFM\BFPB\FY 2002\OMB Bush Budget\Program Level 3/31/2001

Sub Sub Activity	2000 Actual Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level	2001 Appropriation Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,005,407 2/	39,354	392,340 3/	0	1,437,101	1,084,173	39,960	430,841 3/	0	1,554,974
Dental Health	80,062	0	0	0	80,062	91,018	0	0	0	91,018
Mental Health	43,245	0	0	0	43,245	45,018	0	0	0	45,018
Alcohol & Substance Abuse	96,824	0	0	0	96,824	130,254 4/	0	0	0	130,254
Contract Health Services	406,756	0	0	0	406,756	445,773	0	0	0	445,773
Total, Clinical Svcs	1,632,294	39,354	392,340	0	2,063,988	1,796,236	39,960	430,841	0	2,267,037
Public Health Nursing	34,452	0	0	0	34,452	36,114	0	0	0	36,114
Health Education	9,625	0	0	0	9,625	10,063	0	0	0	10,063
Comm. Health Reps	46,380	0	0	0	46,380	48,061	0	0	0	48,061
Immunization AK	1,402	0	0	0	1,402	1,471	0	0	0	1,471
Total, Prev Hlth	91,859	0	0	0	91,859	95,709	0	0	0	95,709
Urban Health	27,813	0	0	0	27,813	29,843	0	0	0	29,843
Indian Health Professions	30,491	0	0	0	30,491	30,486	0	0	0	30,486
Tribal Management	2,411	0	0	0	2,411	2,406	0	0	0	2,406
Direct Operation	50,988	0	0	0	50,988	52,946	0	0	0	52,946
Self Governance	9,531	0	0	0	9,531	9,803	0	0	0	9,803
Contract Support Costs	228,781	0	0	0	228,781	248,234	0	0	0	248,234
Total, Services	2,074,168	39,354	392,340	0	2,505,862	2,265,663	39,960	430,841	0	2,736,464
FACILITIES:										
Maint. & Improvement	43,433	0	0	4,700	48,133	46,331	0	0	4,700	51,031
Sanitation Facilities	92,117	0	0	0	92,117	93,617	0	0	0	93,617
Hlth Care Facs. Constr.	50,393	0	0	0	50,393	85,525	0	0	0	85,525
Facil. & Envir. Hlth Support	116,282	0	0	0	116,282	121,336	0	0	0	121,336
Equipment	14,330	0	0	0	14,330	16,294	0	0	0	16,294
Total, Facilities	316,555	0	0	4,700	321,255	363,103	0	0	4,700	367,803
Total, IHS	2,390,723	39,354	392,340	4,700	2,827,117	2,628,766	39,960	430,841	4,700	3,104,267
Advance Transfer Appropriation:										
Diabetes 1/	30,000	0	0	0	30,000	100,000	0	0	0	100,000
GRAND TOTAL	2,420,723	39,354	392,340	4,700	2,857,117	2,728,766	39,960	430,841	4,700	3,204,267

1/ The Balanced Budget Act of 1997 transfers $30,000,000 annually to IHS for diabetes prevention and treatment for FY 1998 through FY 2002. An additional $70,000,000 a year received under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 for FY 2001 and FY 2002, and $100,000,000 is available for FY 2003.

2/ FY 2000 appropriation reduced by $5,000 as a result of CFO/CIO transfer.

3/ Includes $29,203,000 in Medicaid/Medicare for tribal collection estimates.

4/ Includes $30,000,000 in the final FY 2001 Labor/HHS Appropriation.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

FILE: O:\DFM\BFPB\FY 2002\OMB Bush Budget\Program Level

3/31/2001

Sub Sub Activity	2002 Estimate Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level	Increase/Decrease Of 2002 Over 2001 Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,137,711	39,960	460,025 2/	0	1,637,696	53,538	0	29,184	0	82,722
Dental Health	95,305	0	0	0	95,305	4,287	0	0	0	4,287
Mental Health	47,142	0	0	0	47,142	2,124	0	0	0	2,124
Alcohol & Substance Abuse	135,005	0	0	0	135,005	4,751	0	0	0	4,751
Contract Health Services	445,776	0	0	0	445,776	3	0	0	0	3
Total, Clinical Svcs	1,860,939	39,960	460,025	0	2,360,924	64,703	0	29,184	0	93,887
Public Health Nursing	37,781	0	0	0	37,781	1,667	0	0	0	1,667
Health Education	10,628	0	0	0	10,628	565	0	0	0	565
Comm. Health Reps	49,789	0	0	0	49,789	1,728	0	0	0	1,728
Immunization AK	1,526	0	0	0	1,526	55	0	0	0	55
Total, Prev Hlth	99,724	0	0	0	99,724	4,015	0	0	0	4,015
Urban Health	29,947	0	0	0	29,947	104	0	0	0	104
Indian Health Professions	30,565	0	0	0	30,565	79	0	0	0	79
Tribal Management	2,406	0	0	0	2,406	0	0	0	0	0
Direct Operation	65,323	0	0	0	65,323	12,377	0	0	0	12,377
Self Governance	9,876	0	0	0	9,876	73	0	0	0	73
Contract Support Costs	288,234	0	0	0	288,234	40,000	0	0	0	40,000
Total, Services	2,387,014	39,960	460,025	0	2,886,999	121,351	0	29,184	0	150,535
FACILITIES:										
Maint. & Improvement	45,331	0	0	4,700	50,031	(1,000)	0	0	0	(1,000)
Sanitation Facilities	93,827	0	0	0	93,827	210	0	0	0	210
Hlth Care Facs. Constr.	37,568	0	0	0	37,568	(47,957)	0	0	0	(47,957)
Facil. & Envir. Hlth Support	126,775	0	0	0	126,775	5,439	0	0	0	5,439
Equipment	16,294	0	0	0	16,294	0	0	0	0	0
Total, Facilities	319,795	0	0	4,700	324,495	(43,308)	0	0	0	(43,308)
Total, IHS	2,706,809	39,960	460,025	4,700	3,211,494	78,043	0	29,184	0	107,227
Advance Transfer Appropriation:										
Diabetes 1/	100,000	0	0	0	100,000	0	0	0	0	0
GRAND TOTAL	2,806,809	39,960	460,025	4,700	3,311,494	78,043	0	29,184	0	107,227

1/ The Balanced Budget Act of 1997 tranfers $30,000,000 annually to IHS for diabetes prevention and treatment for FY 1998 through FY 2002. An additional $70,000,000 a year received under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 for FY 2001 and FY 2002, and $100,000,000 is available for FY 2003.

2/ Includes $29,203,000 in Medicaid/Medicare for tribal collection estimates.

INDIAN HEALTH SERVICE
FTE Summary

02-Apr-01

Sub Sub Activity	2000 Actual	2001 Appropriation	2002 Estimate
SERVICES:			
Hospital & Health Clinics	6,877	6,953	7,047
Dental Health	745	763	781
Mental Health	283	297	303
Alcohol & Substance Abuse	172	172	172
Contract Health Services	0	0	0
Total, Clinical Services	8,077	8,185	8,303
Public Health Nursing	287	289	294
Health Education	35	36	39
Community Health Reps	0	0	0
Immunization, AK	0	0	0
Total, Preventive Hlth	322	325	333
Urban Health	5	5	5
Indian Health Professions 1/	20	20	20
Tribal Management	0	0	0
Direct Operations	1,629	1,629	1,629
Self Governance	9	9	9
Contract Support Costs	0	0	0
Total, Services	10,062	10,173	10,299
FACILITIES:			
Maint. & Improvenment	0	0	0
Sanitation Facilities	197	197	197
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support:			
Fac. Support	535	550	557
Env. Health Support	440	459	460
OEHE Support	62	65	65
Total, F&EHS	1,037	1,074	1,082
Equipment	0	0	0
Total, Facilities	1,234	1,271	1,279
Total, Services and Facilities	11,296	11,444	11,578
COLLECTIONS:			
Medicare	881	881	881
Medicaid	2,011	2,011	2,011
Private Insurance	447	447	447
Quarters	41	41	41
Total, Collections	3,380	3,380	3,380
Grand Total IHS	**14,676**	**14,824**	**14,958**

INDIAN HEALTH SERVICE
FTE Summary
Detail of Changes

04/02/01

Sub Sub Activity	2001 Appropriation	Non-add Staffing of New Facs.	Staffing Of New Facilities	2002 Estimate
SERVICES:				
Hospital & Health Clinics	6,953	0	94	7,047
Dental Health	763	0	18	781
Mental Health	297	0	6	303
Alcohol & Substance Abuse	172	0	0	172
Contract Health Services	0	0	0	0
Total, Clinical Services	8,185	0	118	8,303
Public Health Nursing	289	0	5	294
Health Education	36	0	3	39
Community Health Reps	0	0	0	0
Immunization, AK	0	0	0	0
Total, Preventive Hlth	325	0	8	333
Urban Health	5	0	0	5
Indian Health Professions	20	0	0	20
Tribal Management	0	0	0	0
Direct Operations	1,629	0	0	1,629
Self Governance	9	0	0	9
Contract Support Costs	0	0	0	0
Total, Services	10,173	0	126	10,299
FACILITIES:				
Maint. & Improvenment	0	0	0	0
Sanitation Facilities	197	0	0	197
Hlth Care Facs Construction	0	0	0	0
Facil. & Envir. Hlth Support:				
Fac. Support	550	0	7	557
Env. Health Support	459	0	1	460
OEHE Support	65	0	0	65
Total, F&EHS	1,074	0	8	1,082
Equipment	0	0	0	0
Contract Support Costs	0	0	0	0
Total, Facilities	1,271	0	8	1,279
Total, Services and Facilities	11,444	0	134	11,578
Collections:				
Medicare	881	0	0	881
Medicaid	2,011	0	0	2,011
Private Insurance	447	0	0	447
Quarters	41	0	0	41
Total, Collections	3,380	0	0	3,380
Grand Total IHS	**14,824**	**0**	**134**	**14,958**

INDIAN HEALTH SERVICE
PHASING-IN OF STAFFING/OPERATING COST
FY 2002 Budget Request
(Dollars in Thousands)

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Sub Sub Activity	Ft. Defiance, AZ Hospital		Parker, AZ Health Center		GRAND TOTAL	
	FTE	Amount	FTE	Amount	FTE	Amount
Hospital & Health Clinics	14	1,079	80	6,093	94	$7,172
Dental Health	0	0	18	1,445	18	1,445
Mental Health	0	0	6	534	6	534
Contract Health Services	0	0	0	0	0	0
Total, Clinical Services	14	1,079	104	8,072	118	9,151
Public Health Nursing	0	0	5	423	5	423
Health Education	0	0	3	262	3	262
Community Hlth Repr.	0	0	0	0	0	0
Total, Prev Hlth	0	0	8	685	8	685
Total, Services	14	$1,079	112	$8,757	126	9,836
Facilities Support	1	131	6	963	7	1,094
Envir. Hlth Support	0	0	1	70	1	70
Total, Facilities	1	$131	7	$1,033	8	$1,164
Grand Total	15	$1,210	119	$9,790	134	$11,000

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2000 Crosswalk
Budget Authority
Estimated Distribution
($000)

03/31/01
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Sub Activity	Federal Health Administration: Federal Clinical Services	Urban Health	Prev. Health	Indian Health Prof.	Federal Admini-stration	Self - Gov.	Facil-ities	Total Federal Health Admini-stration	Tribal Health Administration: Tribal Clinical Services	Tribal Prev. Health	Urban Health	Manage-ment Training	Self - Gov.	Tribal Contract Support	Facil-ities	Total Tribal Health Admini-stration	2,000 Actual
SERVICES																	
Hospitals & Health Clinics	557,831	0	0	0	0	0	0	557,831	447,576	0	0	0	0	0	0	447,576	1,005,407
Dental Health	51,091	0	0	0	0	0	0	51,091	28,971	0	0	0	0	0	0	28,971	80,062
Mental Health	23,265	0	0	0	0	0	0	23,265	19,980	0	0	0	0	0	0	19,980	43,245
Alcohol & Substance Abuse	15,930	0	0	0	0	0	0	15,930	80,894	0	0	0	0	0	0	80,894	96,824
Contract Health Services	210,283	0	0	0	0	0	0	210,283	196,473	0	0	0	0	0	0	196,473	406,756
Subtotal (CS)	858,400	0	0	0	0	0	0	858,400	773,894	0	0	0	0	0	0	773,894	1,632,294
																	0
Public Health Nursing	0	0	19,332	0	0	0	0	19,332	0	15,120	0	0	0	0	0	15,120	34,452
Health Education	0	0	2,719	0	0	0	0	2,719	0	6,906	0	0	0	0	0	6,906	9,625
Community Hlth Repr.	0	0	578	0	0	0	0	578	0	45,802	0	0	0	0	0	45,802	46,380
Hep B/Haemophilus Influenzae Prog Alaska	0	0	0	0	0	0	0	0	0	1,402	0	0	0	0	0	1,402	1,402
Subtotal (PH)	0	0	22,629	0	0	0	0	22,629	0	69,230	0	0	0	0	0	69,230	91,859
Urban Health Projects	0	2,121	0	0	0	0	0	2,121	0	0	25,692	0	0	0	0	25,692	27,813
Indian Hlth Professions	0	0	0	30,491	0	0	0	30,491	0	0	0	0	0	0	0	0	30,491
Tribal Management	0	0	0	0	40	0	0	40	0	0	0	2,371	0	0	0	2,371	2,411
Direct Operations	0	0	0	0	41,112	0	0	41,112	0	0	0	9,876	0	0	0	9,876	50,988
Self Governance	0	0	0	0	0	1,776	0	1,776	0	0	0	0	7,755	0	0	7,755	9,531
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	228,781	0	228,781	228,781
Total Services	858,400	2,121	22,629	30,491	41,152	1,776	0	956,569	773,894	69,230	25,692	12,247	7,755	228,781	0	1,117,599	2,074,168
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	24,990	24,990	0	0	0	0	0	0	18,443	18,443	43,433
Sanitation Facilities:	0	0	0	0	0	0	11,054	11,054	0	0	0	0	0	0	81,063	81,063	92,117
Hlth Care Facs. Constr.	0	0	0	0	0	0	36,624	36,624	0	0	0	0	0	0	13,769	13,769	50,393
Facs. & Env. Hlth Sup	0	0	0	0	0	0	90,947	90,947	0	0	0	0	0	0	25,335	25,335	116,282
Equipment	0	0	0	0	0	0	8,593	8,593	0	0	0	0	0	0	5,737	5,737	14,330
Total, Facilities	0	0	0	0	0	0	172,208	172,208	0	0	0	0	0	0	144,347	144,347	316,555
TOTAL IHS	858,400	2,121	22,629	30,491	41,152	1,776	172,208	1,128,777	773,894	69,230	25,692	12,247	7,755	228,781	144,347	1,261,946	2,390,723

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Sub Activity	Federal Health Administration: Federal Clinical Services	Urban Health	Prev. Health	Indian Health Prof.	Federal Admini-stration	Self - Gov.	Facil-ities	Total Federal Health Admini-stration	Tribal Health Administration: Tribal Clinical Services	Tribal Prev. Health	Urban Health	Manage-ment Training	Self - Gov.	Tribal Contract Support	Facil-ities	Total Tribal Health Admini-stration	2,001 Appropriaiton
SERVICES																	
Hospitals & Health Clinics	616,167	0	0	0	0	0	0	616,167	468,006	0	0	0	0	0	0	468,006	1,084,173
Dental Health	56,917	0	0	0	0	0	0	56,917	34,101	0	0	0	0	0	0	34,101	91,018
Mental Health	24,259	0	0	0	0	0	0	24,259	20,759	0	0	0	0	0	0	20,759	45,018
Alcohol & Substance Abuse	16,271	0	0	0	0	0	0	16,271	113,983	0	0	0	0	0	0	113,983	130,254
Contract Health Services	241,638	0	0	0	0	0	0	241,638	204,135	0	0	0	0	0	0	204,135	445,773
Subtotal (CS)	955,252	0	0	0	0	0	0	955,252	840,984	0	0	0	0	0	0	840,984	1,796,236
																	0
Public Health Nursing	0	0	20,402	0	0	0	0	20,402	0	15,712	0	0	0	0	0	15,712	36,114
Health Education	0	0	2,888	0	0	0	0	2,888	0	7,175	0	0	0	0	0	7,175	10,063
Community Hlth Repr.	0	0	498	0	0	0	0	498	0	47,563	0	0	0	0	0	47,563	48,061
Hep B/Haemophilus Influenzae Prog Alaska	0	0	0	0	0	0	0	0	0	1,471	0	0	0	0	0	1,471	1,471
Subtotal (PH)	0	0	23,788	0	0	0	0	23,788	0	71,921	0	0	0	0	0	71,921	95,709
Urban Health Projects	0	2,149	0	0	0	0	0	2,149	0	0	27,694	0	0	0	0	27,694	29,843
Indian Hlth Professions	0	0	0	30,486	0	0	0	30,486	0	0	0	0	0	0	0	0	30,486
Tribal Management	0	0	0	0	0	0	0	0	0	0	0	2,406	0	0	0	2,406	2,406
Direct Operations	0	0	0	0	42,685	0	0	42,685	0	0	0	10,261	0	0	0	10,261	52,946
Self Governance	0	0	0	0	0	1,746	0	1,746	0	0	0	0	8,057	0	0	8,057	9,803
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	248,234	0	248,234	248,234
Total Services	955,252	2,149	23,788	30,486	42,685	1,746	0	1,056,106	840,984	71,921	27,694	12,667	8,057	248,234	0	1,209,557	2,265,663
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	26,092	26,092	0	0	0	0	0	0	20,239	20,239	46,331
Sanitation Facilities:	0	0	0	0	0	0	11,234	11,234	0	0	0	0	0	0	82,383	82,383	93,617
Hlth Care Facs. Constr.	0	0	0	0	0	0	52,910	52,910	0	0	0	0	0	0	32,615	32,615	85,525
Facs. & Env. Hlth Sup	0	0	0	0	0	0	94,642	94,642	0	0	0	0	0	0	26,694	26,694	121,336
Equipment	0	0	0	0	0	0	8,593	8,593	0	0	0	0	0	0	7,701	7,701	16,294
Total, Facilities	0	0	0	0	0	0	193,471	193,471	0	0	0	0	0	0	169,632	169,632	363,103
TOTAL IHS	955,252	2,149	23,788	30,486	42,685	1,746	193,471	1,249,577	840,984	71,921	27,694	12,667	8,057	248,234	169,632	1,379,189	2,628,766

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Sub Activity	Federal Health Administration: Federal Clinical Services	Urban Health	Prev. Health	Indian Health Prof.	Federal Admini-stration	Self - Gov.	Facil-ities	Total Federal Health Admini-stration	Tribal Health Administration: Tribal Clinical Services	Tribal Prev. Health	Urban Health	Manage-ment Training	Self - Gov.	Tribal Contract Support	Facil-ities	Total Tribal Health Admini-stration	2,002 Estimate
SERVICES																	
Hospitals & Health Clinics	487,106	0	0	0	0	0	0	487,106	650,605	0	0	0	0	0	0	650,605	1,137,711
Dental Health	43,680	0	0	0	0	0	0	43,680	51,625	0	0	0	0	0	0	51,625	95,305
Mental Health	19,011	0	0	0	0	0	0	19,011	28,131	0	0	0	0	0	0	28,131	47,142
Alcohol & Substance Abuse	11,984	0	0	0	0	0	0	11,984	123,021	0	0	0	0	0	0	123,021	135,005
Contract Health Services	183,255	0	0	0	0	0	0	183,255	262,521	0	0	0	0	0	0	262,521	445,776
Subtotal (CS)	745,036	0	0	0	0	0	0	745,036	1,115,903	0	0	0	0	0	0	1,115,903	1,860,939
																	0
Public Health Nursing	0	0	15,082	0	0	0	0	15,082	0	22,699	0	0	0	0	0	22,699	37,781
Health Education	0	0	3,159	0	0	0	0	3,159	0	7,469	0	0	0	0	0	7,469	10,628
Community Hlth Repr.	0	0	376	0	0	0	0	376	0	49,413	0	0	0	0	0	49,413	49,789
Hep B/Haemophilus Influenzae Prog Alaska	0	0	0	0	0	0	0	0	0	1,526	0	0	0	0	0	1,526	1,526
Subtotal (PH)	0	0	18,617	0	0	0	0	18,617	0	81,107	0	0	0	0	0	81,107	99,724
Urban Health Projects	0	794	0	0	0	0	0	794	0	0	29,153	0	0	0	0	29,153	29,947
Indian Hlth Professions	0	0	0	30,565	0	0	0	30,565	0	0	0	0	0	0	0	0	30,565
Tribal Management	0	0	0	0	0	0	0	0	0	0	0	2,406	0	0	0	2,406	2,406
Direct Operations	0	0	0	0	41,421	0	0	41,421	0	0	0	23,902	0	0	0	23,902	65,323
Self Governance	0	0	0	0	0	1,489	0	1,489	0	0	0	0	8,387	0	0	8,387	9,876
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	288,234	0	288,234	288,234
Total Services	745,036	794	18,617	30,565	41,421	1,489	0	837,922	1,115,903	81,107	29,153	26,308	8,387	288,234	0	1,549,092	2,387,014
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	19,121	19,121	0	0	0	0	0	0	26,210	26,210	45,331
Sanitation Facilities:	0	0	0	0	0	0	68,590	68,590	0	0	0	0	0	0	25,237	25,237	93,827
Hlth Care Facs. Constr.	0	0	0	0	0	0	20,500	20,500	0	0	0	0	0	0	17,068	17,068	37,568
Facs. & Env. Hlth Sup	0	0	0	0	0	0	83,186	83,186	0	0	0	0	0	0	43,589	43,589	126,775
Equipment	0	0	0	0	0	0	6,753	6,753	0	0	0	0	0	0	9,541	9,541	16,294
Total, Facilities	0	0	0	0	0	0	198,150	198,150	0	0	0	0	0	0	121,645	121,645	319,795
TOTAL IHS	745,036	794	18,617	30,565	41,421	1,489	198,150	1,036,072	1,115,903	81,107	29,153	26,308	8,387	288,234	121,645	1,670,737	2,706,809
								38.3%									

NOTE: Tribal Health Administration includes Navajo Conversion of $303,097,000 from Federal Health Administration.

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EXECUTIVE SUMMARY

GENERAL STATEMENT

The Indian Health Service (IHS) has the responsibility for the delivery of health services to Federally-recognized American Indians and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The **Mission** of the agency is to raise the physical, mental, social, and spiritual health of AI/AN to the highest level, in partnership with the population served. The agency **Goal** is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. The mission and goal are addressed through four **Strategic Objectives**, which are: 1) Improve health status; 2) Provide health services; 3) Assure partnerships and consultation with I/T/U; and 4) Perform core functions.

OVERVIEW OF THE BUDGET

This budget request and performance plan represents the next incremental step necessary to eliminate the health disparities that prevail in the AI/AN population. It is consistent with the Agency's mission, the Department's strategic plan, and HHS' efforts to eliminate racial and ethnic disparities in health.

The Indian Health Service proposes **an increase of $78.043 million and 134 FTE** in FY 2002 above the FY 2001 President's Budget Request. This budget would provide an additional $78.043 million to restore access to basic health care, including current services, contract support costs, and health care facilities construction, and $12.0 million in program increases for Services. These investments aim: 1) to improve the I/T/U capacity and infrastructure to provide access to high quality primary and secondary medical services, and basic preventive services, and 2) to halt the recent **declines in certain health status indicators**.

POLICY BASIS AND FORMULATION PROCESS FOR FY 2002 BUDGET REQUEST

The Federal Commitment is to Raise AI/AN Health Status in Partnership with Tribal Governments.

From a policy perspective, this budget request is perhaps the most strongly supported proposal in the Agency's history; it is based on both new and longstanding Federal policy and commitment for improving health status by assuring the availability of basic health care services for members of federally recognized Indian tribes. The request supports the following three policy initiatives:

- HHS' effort to eliminate racial and ethnic disparities in health.
- the proposed **HHS Healthy People 2010** and its goal of achieving equivalent and improved health status for all Americans over the next decade,
- the DHHS Strategic Plan:

- Goal 1 - Reduce major threats to health and productivity of all Americans.

- Goal 2 - Improve the economic and social well being of individuals and families, and communities in the United States.

- Goal 3 - Improve accesses to health services and ensures the integrity of the Nation's health entitlement and safety net program.

- Goal 4 - Improve the quality of health care and human services.

- Goal 5 - Improve public health systems.

In addition, the Indian Health Care Improvement Act also reflects the reaffirmation of the U.S. government's commitment to Indian tribes to improve the health of their people. The Act states "The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people to **assure the highest possible health status** for Indians and urban Indians and to provide all the resources necessary to affect that policy."

BUDGET PRIORITIES AND STRATEGIES

The primary policy basis for this budget request is eliminating health disparities between the AI/AN population and the general U.S. population. This budget request supports this intent by **improving access** to the basic health services, including assuring that **facilities and equipment** are available for the provision of health services, **contract support services** are available to the tribal health delivery system, and **holding the line against declines in health status.**

This budget is intended to enhance the integration of clinical expertise from medical, behavioral health, and community health staff in order to address the top health problems identified by the I/T/U. The community-based public health model is strengthened by emphasizing prevention strategies throughout the clinical service activities as well as expanding the community health programs and supporting partnerships with community resources such as public safety programs, schools, and other community based organizations.

Improving Access to Basic Health Care - $78.043 million

The first priority in the budget proposal is to **maintain access** to basic health services. The IHS has demonstrated the ability to effectively utilize available resources to provide effective services and improve the health status of the AI/AN people. However, this **record of achievement has eroded** in recent years. To address access to essential individual and community health services, the Areas I/T/U identified funding current services items as their first priority for budget increases for FY 2001. The requested funds provide the next investment required to enhance the I/T/U public health system to a level that can reduce health disparities by providing access to high quality medical and preventive services.

An essential component of supporting access to services and improving health status in the long run is to assure that **facilities and equipment** are available for the provision of health services. The average age of IHS

facilities is 32 years. The age of facilities make the efficient, safe, and pleasant provision of services difficult at some locations.

Also critical is the provision of contract support services to the tribal health delivery system. These requested funds are necessary for tribal communities to assure that there are utilities, training, clerical staff, administrative and financial services needed to operate health programs. Without this funding, the supports are either not available, or these services must be funded from resources that would otherwise fund health service activities. This investment is consistent with the goals to expanding tribal participation in the management of the programs and the principles of the Indian Self-Determination Act.

Reducing the Gap in Health Disparities - $12.0 million

The Budget also targeted funds to move forward towards health improvements. The request addresses the multiple health issues affecting the AI/AN population and is the beginning of a long-term plan for continuing improvements in the health of the AI/AN population. The proposal targets the health problems identified as highest priority by the I/T/U and responsible for much of the disparity in health status for the AI/AN population. These include alcoholism and substance abuse, diabetes, cancer, mental health, elder health, heart disease, injuries, dental health, maternal and child health, domestic violence, infectious diseases, and sanitation. The support for public health infrastructure is also fundamental to these initiatives. These investments will support surveillance, prevention and treatment services and are based on "best practices" defined in health literature. These targeted efforts will be monitored in the performance plan.

Another need is water and sewer systems for new and existing homes at the community level. The AI/AN homes are seven times more likely to be without clean water than homes in the broader U.S. This construction need must be addressed if further progress is to be made in preventing infectious diseases and improving the quality of life.

Medicare/Medicaid Collections

The IHS anticipates that it will collect an additional $29,184,000 in Medicare and Medicaid collections in FY 2002. An increase is anticipated because of IHS' new legislative authority to bill Medicare for physician services and because of IHS' reimbursement rate increases for Medicare and Medicaid in FY 2001.

Expansion of the HHS Secretary's L/HHS Appropriations Transfer Authority

The FY 2002 Budget proposes to include IHS in HHS' Departmental Transfer Authority. This transfer authority will allow HHS to assist the IHS in responding to emerging public health issues. Language authorizing this transfer is proposed for inclusion in the Labor, Health and Human Services, Education, and Related Agencies Appropriation Act General Provisions.

Conclusion

In summary this budget request and performance plan will improve access to individual and community health services. The request provides the next increment required enhancing the I/T/U public health system so that it can

again continue to make significant improvements in the health status of AI/AN people.

FY 2002 Budget Request Summary
(Services and Facilities)

	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$2,390,723,000	$2,628,766,000	$2,706,809,000	+$316,086,000	+$78,043,000
Program Level..1/	$2,857,117,000	$3,204,267,000	$3,311,494,000	+$454,377,000	+$107,227,000
FTE.....	14,676	14,824	14,958	+282	+134

1/ The Balanced Budget Act of 1997 included an increase of $30,000,000 for the prevention and treatment of diabetes. This amount will be available each year through FY 2002. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 provided an additional $70,000,000 in FY 2001 and FY 2002 and $100,000,000 for FY 2003.

The request of $2,706,809,000 and 14,958 FTE is a net increase of $78,043,000 and 134 FTE over the FY 2001 appropriation of $2,628,766,000 and 14,824 FTE. The formulation process included tribal and urban consultation and participation throughout. The following summarizes the IHS Budget Request:

IMPROVING ACCESS - FY 2001 Current Services: +$153,568,000 and 134 FTE

The IHS is requesting an increase of $153,568,000 for Current Services that includes funding for pay raises, inflation (tribal pay cost and other), Contract Support Costs, new staffing and related operating costs for new facilities, and health care facilities replacement construction projects. All current service funding pays for annual costs that are attributable to the rapidly expanding AI/AN population and required to maintain the current level of health care provided. The current services increase of $153,568,000 includes the following:

- $32,000,000 for Pay Costs.
- $23,000,000 for Inflation (tribal pay cost).
- $11,000,000 and 134 FTE for Phasing-In of Staffing and Operating Costs for new facilities.
- $37,568,000 for the following health care facilities construction projects: for equipment for Ft Defiance, AZ Hospital ($11,326,000); for the completion of the Winnebago, NE Hospital ($23,241,000); for Ft. Defiance Quarters ($3,001,000).
- $40,000,000 for Contract Support Costs.
- $10,000,000 for Federal Cost of Navajo Conversion.

REDUCING THE GAP - Program Increases: $12,000,000

The program increases of $12,000,000 includes the following:

- $8,000,000 for Indian Health Care Improvement Fund.
- $4,000,000 for Information Technology.

Program Decreases: -$87,525,000

- -$85,525,000 for Non-recurring Health Care Facilities Construction Funds
- -$ 1,000,000 for One Time Project: Urban Health (SIPI).
- -$ 1,000,000 for One Time Project: Maintenance & Improvement (AMEX).

GENERAL STATEMENT

	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Health Services	$2,074,168,000	$2,265,663,000	$2,387,014,000	+$312,846,000	+$121,351,000
Facilities	316,555,000	363,103,000	319,795,000	+$3,240,000	-$43,308,000
Total, Budget Authority	$2,390,723,000	$2,628,766,000	$2,706,809,000	+$316,086,000	+$ 78,043,000
Reimbursement	$436,394,000	$475,501,000	$504,685,000	+$68,291,000	+$29,184,000
Diabetes 1/	30,000,000	100,000,000	100,000,000	+70,000,000	-0-
Total, Program Level	$2,857,117,000	$3,204,267,000	$3,311,494,000	+$454,377,000	+$107,227,000

1/ The Balanced Budget Act of 1997 transfers $30,000,000 annually to IHS for diabetes prevention and treatment from FY 1998 through FY 2002. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 provided an additional $70,000,000 in FY 2001 and FY 2002, and $100,000,000 for FY 2003.

United States Government and Indian Nations

The provision of Federal health services to American Indians and Alaska Natives (AI/AN) is based on a special relationship between Indian tribes and the United States provided by Article I, Clause 8, of the United States Constitution. Numerous treaties, statutes, and court decisions first expounded in the 1830's by the U.S. Supreme Court under Chief Justice John Marshall have reconfirmed this relationship. Principal among these is the Snyder Act (25 U.S.C.) of 1921 that provides the basic authority for most health services provided by the Federal Government to AI/AN.

In order to develop stronger partnership between the government and tribal governments, the Department of Health and Human Services and IHS have conducted regional meetings with tribes on an annual basis since 1995. The meetings fostered new partnerships between the government, state, and tribes to meet the health needs of Indian people.

The Indian Health Service and Its Partnership with Tribes

For more than 120 years, the responsibility of AI/AN health care passed among different government branches. In 1955, the responsibility for providing health care to AI/AN was officially transferred to the Public Health Service (PHS).

In the 1970's, federal Indian policy was re-evaluated by the Nixon Administration, and the Indian self-determination policy was adopted. This policy emphasizes tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any federal treaty obligation, but provides an opportunity for tribes to assume the responsibility of providing health care for their members.

The Indian Self-Determination and Education Assistance Act of 1975, as amended, and the Indian Health Care Improvement Act of 1976, as amended, gave new opportunities and responsibilities to the IHS and tribes in delivering care. These included specific authorizations for providing health care services to Indian urban populations, an Indian health professions program, and the ability to collect from Medicare/Medicaid and other third party insurers. Under the Indian Self-Determination Act, many

tribes have assumed the administrative and program direction roles that were previously carried out by the Federal government. Tribes through Self-Determination contracts or Self-Governance compacts administer over one-half of IHS resources. IHS facilities and providers for the direct provision of services to AI/AN utilize the remaining resources where tribes have elected not to contract or compact their health program at this time, and to purchase care from private health care providers and facilities.

To continue strengthening the federal-tribal partnership, IHS implemented a new budget formulation procedure for FY 1999 integrating the Government Performance and Results Act (GPRA), Public Law 93-638, and annual budget formulation into an iterative process that gives local I/T/U more opportunities for annual budget policy input and review. This process was continued in developing the FY 2002 budget request. Work sessions in all 12 Areas initiated the FY 2002 formulation process and established the health priorities with associated budget priorities on which the FY 2002 budget is based.

The Mission, Goal, and Vision

The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/AN to the highest level, in partnership with the population served.

The Director of the IHS has articulated a vision for the Agency on an annual basis. The IHS vision is to continue to be the best primary care, rural health system in the world. A system that, with tribes, continues its goal of assuring that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. To reach its goal, the clinical program is made up of many separate activities including maternal and child health; fetal alcohol syndrome; diabetes; alcoholism; mental health; emergency medical services; community health representatives; hepatitis B; dental services; and many others. These programs possess curative and preventive components to a degree unparalleled in any similar program. In addition to these clinically based programs, the Agency also encourages a community based environmental health program, sanitation facilities construction program and health facilities construction program.

The IHS program is delivered to a service population of more than 1.5 million AI/ANs through 153 Service Units composed of 568 direct health care delivery facilities, including 49 hospitals, 219 health centers, 7 school health centers, and 293 health stations, satellite clinics, and Alaska village clinics. Within this system, Indian tribes deliver IHS funded services to their own communities with over 44 percent of the IHS budget in 13 hospitals, 161 health centers, 3 school health centers, and 249 health stations and Alaska village clinics. Tribes who have elected to retain the federal administration of their health services, or to defer tribal assumption of the IHS program until a later time receive services with about 56 percent of the IHS budget in 36 hospitals, 58 health centers, 4 school health centers, and 44 health stations. The range of services includes traditional inpatient and ambulatory care, and extensive preventive care, including focused efforts toward health promotion and disease prevention activities.

In addition, various health care and referral services are provided to Indian people in off-reservation settings through 34 urban programs. Another integral part of the program is the purchase of services from non-IHS providers to support, or in some cases in lieu of, direct care facilities. This Contract Health Services program represents approximately 17 percent of the IHS Budget. The IHS Fiscal Intermediary in FY 2000 processed claims at a total billed amount of $434.5 million. The total paid amount after contract and alternate resource savings was $181 million.

Service Units

Service Units, local administrative units, serve a defined geographic area and are usually centered on a single federal reservation in the continental United States, or a population concentration in Alaska. Within these 153 administrative units, health care is delivered through 219 health centers, 7 school health centers, 123 health stations, 170 Alaska village clinics, and 49 hospitals by tribally and federally operated Indian health programs.

Area Offices

Twelve Area Offices provide resource distribution, program monitoring and evaluation activities, and technical support to all operations whether IHS direct or tribally operated. They serve to support the Service Units and their points of service delivery.

Headquarters

The Headquarters operation are determined by statutes and administrative requirements set forth by the Department of Health and Human Services, the Administration, the Congress, and field operations (Area Offices and Service Units). Headquarters is involved with the Department in formulating and implementing national health care priorities, goals, and objectives. It is involved with the Administration through the Department in budget and legislative formulation, responding to congressional inquiries, and appropriate interaction with other governmental entities. It provides Area Offices and Service Units with general program oversight and direction, policy formulation, and resource distribution. It provides expert technical expertise, maintains national statistics, and project trends and needs for the future.

ACCOMPLISHMENTS

Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. With the funding appropriated between 1988 and 1997, dramatic improvements in mortality rates were realized including:

- Infant mortality reduced 30 percent
- Years of Potential Life Lost decreased 17 percent
- Overall mortality reduced 20 percent
- Maternal mortality reduced 33 percent
- TB mortality rate reduced 53 percent

It is indeed discouraging that recent mortality data (FY 1997) available from the National Center for Health Statistics show a small upward trend in the deaths of AI/AN people since FY 1995 from cancer (all), lung cancer, heart disease, and suicide.

During the past 5 years major strides have been made in reducing traumatic injury among American Indians through the implementation of a broad array of public health measures. These measures include injury surveillance; extensive training for community health practitioners, board-based community coalitions and implementation targeted interventions. A recent analysis of injury deaths indicates a significant downward trend in unintentional injury mortality. For instance, the Navajo Nation motor vehicle deaths have been reduced by almost 40 percent. The IHS Injury Prevention Program Plan describes the necessity of building basic tribal capacity in order to institutionalize change. Injury Prevention is one of the Agency's key health initiatives. Since 1997, IHS has fostered the development of tribal injury prevention programs toward identifying community-specific injury patterns and in implementing targeted injury intervention projects. Annually, more than 300 tribal health and IHS personnel are trained in injury prevention practitioner skills. These people are working in their communities to reduce the incidence of severe injury and death. Although significant progress has been made, much more could be done to reduce the major burden on the health and well being of Indian communities. Even today, many reservations experience injury death and disability at rates 2-5 times higher than other Americans do. The right programs are in place and this successful model could be expanded to other tribes.

In fulfillment of the federal policy to afford Indian tribes the right to control the health care programs serving AI/AN, IHS and Indian tribes negotiated 48 self-governance compacts and 67 annual funding agreements, which will transfer approximately $642 million to 217 tribes in Alaska and 49 tribal governments in the lower 48 States under the Self-Governance Demonstration Project in FY 2001.

The IHS, through a sub-contract, completed an evaluation of four tribal demonstration programs. These sites were authorized under the Indian Health Care Improvement Act to directly bill and collect for Medicaid and Medicare services. Because of the high degree of success, the 106th Congress enacted permanent authority to allow all tribal programs to implement direct billing and collection.

Work on determining an acceptable methodology for measuring health needs of tribes and Indian people was completed in FY 2000 in fulfillment of Congressional direction to IHS. A national tribal work group guided an economic analysis based on actuarial modeling by a health economics firm. Additional technical support was provided by Agency for Health Care Policy and Research staff and IHS staff. The successful conclusion of this project provides the tribal and federal Indian health policy makers with a method of estimating the benefits and costs of the personal medical services for the American Indian population in comparison to a mainstream health benefit package available through the Federal Employees Health Benefit Program (FEHBP).

The IHS successfully conducted extensive consultation with Indian tribes on the distribution of $80 million in new funding appropriated for Contract Health Services and the Indian Health Care Improvement Fund in FY 2001.

Final agency decisions on the distribution of these new program funds will occur by the end of March 2001 and allotment of funds to each of the 12 areas will take place in April 2001. Another $30 million in new Alcohol and Substance Abuse funding will be targeted to prevention activities at the village level in Alaska Area, and, in the other 11 IHS areas, to address data improvement along with the youth and women acute treatment.

In 2001 and 2002, the IHS will continue to focus on strengthening business office management practices including provider documentation training, procedural coding, processing claims and information systems improvements. In FY 2000, IHS wide efforts were initiated to improve each hospital's capability to identify patients who are eligible or may become eligible for third party reimbursement. A major part of this initiative includes the identification of all children who may be eligible for participation in the Children's Health Insurance Program (CHIP). For 2001 and 2002, the IHS will continue working with HCFA and the State Medicaid Offices to help ensure the success of this effort.

Special Concerns

Within the vast IHS program, there are certain categories of health conditions that are of special concern in FY 2002. Specific disease entities identified as priority areas by the I/T/U and responsible for much of the health disparities in health status for AI/AN population are targeted by the proposed budget request through the Indian Health Care Improvement Fund. These include dental diseases, injuries, mental health, alcoholism, and cancers. Investments in public health infrastructure and information systems are also included in the request. The Agency budget supports priority activities designed to increase the capacity to address the top health concerns identified by the Indian tribes and serve the needs of the most vulnerable segments of the AI/AN population including: children, women and elders.

Health care and related facilities construction are another priority essential to assuring further progress in preventing infectious diseases and improving the quality of life.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
Clinical Services

Program Authorization:

Program authorized by 25 U.S.C. 13, Snyder Act, and P.L. 83-568, Transfer Act 42 U.S.C. 2001.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$1,632,294,000	$1,796,236,000	$1,860,939,000	+$228,645,000	+$64,703,000
HIV/AIDS	($2,423,000)	($2,702,000)	($2,754,000)	(+$331,000)	(+$52,000)
FTE	8,077	8,185	8,303	+226	+118
HIV/AIDS	(14)	(14)	(14)	(0)	(0)

Total Request Level -- The Total Request of $1,860,939,000 and 8,303 FTE is an increase of $64,703,000 and 118 FTE over the FY 2001 appropriation of $1,796,236,000 and 8,185 FTE. The explanation of the request is described in the activities that follow.

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HOSPITALS AND HEALTH CLINICS

Indian Health Service

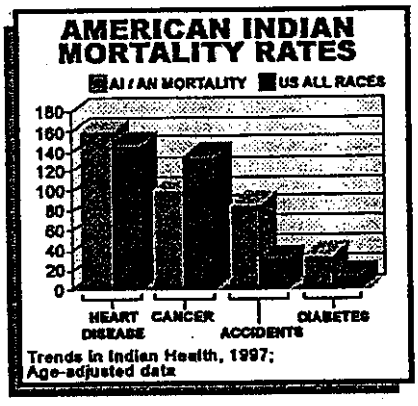
Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Hospitals & Health Clinics					
A. Budget Authority	$1,005,407,000	$1,084,173,000	$1,137,711,000	+$132,304,000	+$53,538,000
B. (HIV/AIDS)	($2,423,000)	($2,702,000)	($2,754,000)	(+$331,000)	($52,000)
C. FTE	6,877	6,953	7,047	+170	+94
D. (HIV/AIDS)	(14)	(14)	(14)	(0)	(0)
E. Activity: Inpatient: # of Days	274,700	273,000	273,000	-1,700	0
Outpatient: # of Visits: Hospitals....	3,750,000	3,832,000	4,880,000	+1,130,000	+1,048,000
Free-Standing Clinic Visits	3,840,000	3,924,500	5,000,000	+1,160,000	+1,075,500
Total, Visits	7,590,000	7,757,000	9,880,000	+2,290,000	+2,123,500

PURPOSE AND METHOD OF OPERATION

Mission Driven Program

The Hospitals and Health Clinics budget provides funding for health care essential to American Indians and Alaska Natives (AI/AN) and critical to the IHS mission. The mission of the agency is to elevate the health status of its service population to the highest possible level and eliminate disparities in health between AI/ANs and the general U.S. population. Since there are significant disparities in the health of AI/AN, this mission is quite challenging.

This element of the budget supports a full range of clinical, preventive, and rehabilitative services and is pivotal to realizing improved health for AI/ANs. As will be described below, while the programs provide high quality services in a cost effective manner, the full range of services is not uniformly available to all Indian communities. This budget request includes targeted increases for this budget activity.



Scope of Services in Isolated Communities is Comprehensive

The Hospitals and Health Clinics budget supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, health education, medical records, physical therapy, nursing, etc. These services are generally unavailable from any other sources in the communities served through IHS. In addition, the program

includes public health initiatives targeting special health conditions that disproportionately affect AI/ANs such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases, including AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elder health and disease surveillance.

Other clinical services, e.g., dentistry and community services (e.g., public health nursing, emergency medical services, and community health representatives) along with a number of health programs operated by the tribes (e.g., the USDA nutrition program for women, infants, and children), and behavioral health services (alcohol, substance abuse, and mental health services) are often housed in the same facilities. This co-location of services in the hospital and clinic increases access and promotes a comprehensive community-oriented program that maximizes the synergistic use of human and capital resources. This also facilitates measurement of outcomes around common goals.

Achieve Quality and Customer Satisfaction

The Hospitals and Health Clinics budget provides annual operating expenses for over 500 health care facilities providing in-patient, routine and emergency ambulatory care, and support services. The IHS and tribal staff of these facilities are committed to delivering the highest quality care possible with available resource. The effect of this commitment is reflected in the continuing success in achieving and maintaining Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation of IHS and tribal-operated facilities. JCAHO, the Accreditation Association of Ambulatory Health Care (AAAHC), and the Health Care Financing Administration (HCFA) regularly and periodically conduct in-depth reviews of the quality of care provided. These accrediting bodies also review the status and safety of the facilities, adequacy and competency of staffing, and management of the service delivery components of the IHS.

These reviews are based upon the concept of continuous quality improvement in clinical programs utilizing specific performance measures to assess quality of care. The IHS and the tribes fully embrace this concept and services are provided and evaluated using the industry benchmarks for customer satisfaction. The average IHS and tribal hospital accreditation grid score has consistently been at or above the average score for all U.S. hospitals (average IHS scores are in the 90's on a scale of 0-100). The most frequently cited area for improvement is the physical plant safety and efficiency.

All 49 of the IHS funded hospitals are JCAHO accredited and 85 percent of the health centers and clinics have achieved accreditation (some are too small to qualify for accreditation). By comparison, less than 50 percent of non-IHS rural hospitals are JCAHO accredited.

Performance Measures Demonstrate Effectiveness

This review process requires that the staffs of the health facility establish performance indicators and demonstrate routine monitoring, analysis, and intervention where the desired outcome is not achieved. Accreditation of individual facilities is based on appropriately established objectives and meeting these standards. Outcome measures

monitored by clinical facilities include clinical programs effectiveness such as obstetrics and childcare, management of acute cardiac events, and emergency situation response.

Service appropriateness is measured in a variety of ways. For example, peripartum care is assessed through such measures as: live births successfully managed; neonate Apgar scores (an objective measure of the infant's health at the end of labor and delivery); maternal morbidity measures such as preventable vaginal lacerations, etc.; and the hospital course of the mother and child as measured by morbidity and treatments utilized during the hospital stay. These many measures of peripartum care can be aggregately summarized with one indicator: neonatal mortality. The neonatal mortality rate among AI/AN children in the IHS service population is in fact better than the general U.S. population by 10 percent. Effective outreach activities and accessible clinical service have resulted in a relatively low percentage of low birth weight deliveries and its associated increased infant morbidity and adverse outcomes. The IHS service population rate of low birth weight deliveries is 20 percent below the rate of low birth weight deliveries in the general U.S. population.

> The neonatal mortality rate among AI/AN children in the IHS service population is better than the general U.S. population by 10 percent.

The annual diabetes care audit is another example of monitoring and assessment. Designed to monitor services provided to over 80,000 diabetics, this audit reviews a wide range of performance measures including foot care, eye care, end organ status, and adequacy of blood sugar control. The various measures developed by IHS for this audit are now incorporated into the National Council on Quality Assurance/American Diabetes Association proposal for national performance benchmarks for diabetes care. IHS performance against these standards has been exemplary by achieving or exceeding the proposed goals for each element.

Recently the managed care industry and state governments have proposed and measured HMO performance against a variety of performance measures contained in the HEDIS (Health Plan Employer Data and Information Set) data set. When compared to HMO performance in the broader population, the IHS-funded programs are at the very top in most measures. For example, the HEDIS data set establishes age specific immunization rates for children served under an HMO (or other managed care plan) similar to the HHS HP 2000 goals.

> A survey of Maryland HMO's (including Kaiser, Aetna and 13 other HMO's) found the average immunization rate to be 67 percent. The IHS average for the same goal was 89 percent during the same time period.

Similarly, the Maryland study also revealed that HMO's achieved screening goals for eye exams on diabetic patients at a rate of 40 percent of the target expectation. The IHS conducts eye exams on greater than 55 percent of its diabetic patients utilizing the same target goal.

Some other IHS outreach and prevention program effectiveness measures are not normally measured by private industry making head to head comparisons difficult to make. For instance, IHS funded nutrition education services

uses service provision location to assess penetration of education into the population. More than 30 percent of these activities occur in a community setting in IHS funded programs. IHS believes that these services are crucial for prevention and control yet there is no industry benchmark for comparison. Performance successes assessed through many other health indicators are documented annually in the Agency publications, Trends in Indian Health, and the Regional Differences in Indian Health. These examples indicate that clinical and prevention efforts continuously measure quality through routinely documented, collected, and analyzed data and also highlight the areas where disparities exist.

Training Crucial

This commitment to quality requires regular and specialized training to assure continued success. Thus, the Hospitals and Health Clinics budget activity supports continuing medical education for a wide variety of the health professionals employed by the IHS and tribes. This includes specialized training in quality assurance and case management as well as discipline-specific training. The FY 2001 budget provided some advanced and specialized training for nurses in intensive care unit and operating room skills, nursing management, and the upgrading of Indian individuals from licensed practical nursing to registered nursing. The budget enabled IHS to support quality assurance training through JCAHO, residency training for IHS physicians, residency training for pharmacists, and continuing education of mid-level providers (physician assistants, nurse practitioners, and pharmacy practitioners). These activities are continued in FY 2002.

Managed Care at Work

The Hospitals and Health Clinics activities are enhanced through a managed care process predicated on strategies for providing

- The highest volume of quality services within appropriation.
- And a rational plan for cost recovery and cost avoidance.

One key aspect in demonstrating the success of this approach is the increasing volume of third party recovery by IHS and tribal facilities (cost recovery). The volume of third party recovery increased by 108 percent between 1995 and 2000. The elimination of unnecessary costs through negotiated rates for purchased services and medical products has also assisted in cost avoidance efforts. To manage growing pharmaceutical costs, IHS uses limited formularies in the service sites, bulk purchasing agreements, and other cost containment approaches.

Through prudent and efficient delivery of care, the IHS provides comprehensive services described above for $1,400 per person per year, a cost of more than 50 percent below that of health insurance for Federal employees.

The IHS provides the comprehensive services described above for $1,400 per person per year, a cost of more than 50 percent below that of health insurance for Federal employees. (Federal employees are funded at approximately $2,900 per person per year. See IHS LNF Report). The IHS not only manages care through its quality assurance program, but it manages costs effectively as well.

Community Oriented Primary Care Attacks Changing Disease

The IHS program continues to focus on increasing access to preventive and curative services for the underserved in Indian communities. This is ordinarily dealt with by targeting clinical, preventive, and restorative care to communities. The IHS funded programs utilize a strategy of targeted health programming based on community health status to try and provide the most useful services to the most people.

> The event leading to death or morbidity appears to be acute, but the factors leading to the illness are chronic in nature.

In recent years the diseases affecting AI/ANs have changed and required a change in service focus. The AI/AN disease burden due to acute illness is decreasing while the chronic disease burden is increasing. Significant behavioral determinants often accompany chronic disease. Of particular concern are disease patterns that disrupt families and communities including accidents, suicides, homicides, family violence and chemical dependency. Prevention of these conditions requires a different set of precepts and disciplines, as they are less susceptible to traditional medical model interventions. These prevention strategies are often difficult to maintain since the impact of the programs is often distant in time and community attention to these efforts may wane in the face of more immediate concerns (such as treatment for trauma associated with family violence).

Promising new developments include community-based wellness centers, school and community based-adolescent clinics and community-based health screening services and these give energy to continued investment in such less immediately gratifying efforts. In one case, Zuni, NM, published data in *MMWR*, *Runner's World*, *Diabetes Care*, and *Public Health Reports*, suggesting that the use of the community wellness center reduced dependence on medication among diabetics and that participants required fewer medical visits than those who did not access the wellness center.

This emphasis on community-oriented primary care is particularly well suited to the unique health needs of AI/AN people. The impressive accomplishments of the IHS have resulted from the broad community approach employing public health nurses (PHNs), alcoholism workers, mental health workers, and sanitarians in partnership with the medical/clinical staff. These skills more directly address the community effects of higher unemployment, lower socioeconomic status, and the complications of poor nutrition, sanitation, and housing found in many AI/AN communities.

Maintaining progress made

The progress made utilizing this strategic approach requires maintenance and continued efforts. This budget proposes to increase funding to allow for maintenance (in the face of increased resource and supply cost, increased population, and utilization), and strategic investments to reduce the disparate disease burden among AI/AN people compared to the general U.S. population.

ACCOMPLISHMENTS

The agency made significant progress in addressing chronic diseases. The primary focus has been in treatment and prevention of diabetes. The increases provided have allowed greater access to the most sophisticated interventions available. This includes more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and greater patient compliance with care regimes. A full report on the impact of the diabetes grant program was provided in January 2001 to the Congress and further details are also provided elsewhere in this document.

Additional funding was provided for podiatric services in FY2001. The funds have allowed the addition of a number of podiatrists to provide services at the community level. The most important impact of these funds however was to raise the awareness of all providers of the importance of screening, prevention, and early intervention in changes associated with diabetes. In FY 2001, IHS staff also published material documenting the effectiveness of these strategies in reducing amputations in AI/AN populations. These strategies are being actively disseminated as standards of care for prevention and treatment of diabetic complications.

During FY 2001 the agency also examined the underlying causes and risk factors contributing to the development of diabetes and heart disease. Of particular interest is a report provided to Congress exploring the scope and impact of obesity as a risk factor in the development of chronic disease. This report noted that obesity is three times more frequent among AI/AN children and this disparity persists into adult life. This high rate of obesity clearly contributes to the development of diabetes and heart disease. The report also provided information on promising interventions that may reduce the risk for chronic disease. Some are as simple as the promotion of breast-feeding in infancy and others involve wider community commitment to dietary and exercise interventions. The agency is examining means to disseminate these interventions on a wider basis. The agency has entered into a partnership with the National Heart, Blood, and Lung Institute in three communities to demonstrate the efficacy of community based interventions. These activities show promise and in FY 2001, IHS and NHLBI will explore with tribes means to disseminate these findings and programs.

Other promising partnerships with NIH entities have emerged during FY 2001. Of significance was the funding of Native American Research Centers in Health (NARCH). This program developed in partnership with the National Institute of General Medical Studies (NIGMS) will provide support for tribally controlled research centers to focus on the diseases disparately affecting American Indian and Alaska Native people. It has the added advantage of developing AI/AN researchers who will focus on the communities from which they come. This will help assure that the most scientific understanding of the impact of disease in this unique population is explored and disseminated.

In FY 2001 promising partnerships were also developed with the Centers for Disease Control and Prevention. Of particular significance in this partnership is the enhancement of a variety of public health capabilities serving AI/AN communities. For example, a strong partnership with the CDC diabetes activities is designed to assure that best practices in diabetes management are identified and disseminated using the joint resources of the

CDC Diabetes Translation and Dissemination Program and the IHS Diabetes Program. Another example is the partnership aimed at surveillance and prevention of Hepatitis C initiated in FY 2001. This critical effort is needed since the rates of Hepatitis C appear to be higher in AI/AN populations and it is a preventable disease. Another effort supported by the collaborative activities between CDC and IHS is support for the developing tribal epidemiology centers. This public health capacity is vital to informing tribal leadership and other policy makers about the specifics of health needs and efficacious interventions. It has increased the tribal capacity to exercise the public health functions of government.

The agency has also taken great strides in addressing pharmacy issues during FY 2001. This includes analysis of the factors leading to the steep rise in pharmaceutical costs and the implementation of some interventions to assume greater control of these costs. The interventions initiated or enhanced in FY 2001 to control costs include greater use of bulk purchasing methods, increased use of a limited but more efficacious formulary, and education of providers about specific pharmacoeconomic strategies. This effort was enhanced by the provision of resources for expansion of the IHS pharmacy residency activities. The residency programs now operate in 11 communities and stimulate innovative thinking about the control of pharmaceutical costs and less expensive, but more effective approaches to patient care. Of particular significance is the increase in pharmacist care for such programs as anti-coagulation and cancer chemotherapy management. This provides more in-depth care (under physician supervision) that capitalizes on the unique skills of pharmacists with specialized technical training in these areas.

Emergency services also utilized an increase to improve programs at the community level during FY 2001. The Congress provided funds that assisted the EMS programs in a variety of communities to assure the stability of staffing and the maintenance of vital equipment. It also stimulated new analysis to be completed in FY 2001 that will define the state of the art efforts that exist in rural America and how these might be disseminated. Many community ambulance services in rural America are struggling to survive (both Indian and non-Indian) and the IHS is looking for creative ways to create partnerships that will strengthen local EMS efforts. IHS has entered into a partnership with the Health Resources and Services Administration (HRSA) to jointly examine these issues.

Lastly, the agency has explored and resolved a number of policy issues with the Health Care Financing Administration. These issues included such matters as eligibility and co-payment concerns in the State Children's Health Insurance Program (SCHIP). These efforts were aimed at assuring the greatest possible utilization of resources available to eligible AI/AN patients for services.

Performance Measures

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to achieve the following:

Indicator 1: During FY 2002, continue tracking (i.e., data collection and analyses) Area age-specific diabetes prevalence rates to identify trends in the age-specific prevalence of diabetes

(as a surrogate marker for diabetes incidence) for the AI/AN population.

Indicator 2: During FY 2002, continue the trend of improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 3: During FY 2002, continue the trend of improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.

Indicator 4: During FY 2002, continue the trend of increasing the proportion of I/T/U clients with diagnosed diabetes assessed for dyslipidemia (i. e., LDL cholesterol).

Indicator 5: During FY 2002, continue the trend of increasing the proportion of I/T/U clients with diagnosed diabetes assessed for nephropathy.

Indicator 6: During FY 2002, increase the proportion of women 18 and older that has had a Pap screen in the previous year by 2 percent over the FY 2001 level.

Indicator 7: During FY 2002, increase the proportion of the AI/AN female population over 40 years of age that has received screening mammography in the previous two years by 2 percent over the FY 2001 level.

Indicator 8: During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 2 percent over the FY 2001 level.

Indicator 10: During FY 2002, increase the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 5 percent over the FY 2001 level.

Indicator 20: During FY 2002, maintain 100 percent accreditation of all IHS hospitals and outpatient clinics.

Indicator 21: During FY 2002, establish baseline health care consumer satisfaction levels for all IHS.

Indicator 23: During FY 2002, increase the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) by 1 percent over the FY 2001 level.

Indicator 24: During FY 2002, increase pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 1 percent over the FY 2000 level.

Indicator 26: During FY 2002, reduce injury-related hospitalizations for AI/AN people by 2 percent over the FY 2001 level.

Indicator 29: During FY 2002, maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10

years old, for both intervention pilot sites and non-intervention comparison sites and evaluate community acceptance and participation in program interventions.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$891,824,000	7,991	
1998	$906,801,000	8,020	
1999	$949,140,000	8,067	
2000	$1,005,407,000	6,877	
2001	$1,084,173,000	6,953	Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $1,137,711,000 and 7,047 FTE is an increase of $53,538,000 and 94 FTE over the FY 2001 enacted level of $1,084,173,000 and 6,953 FTE. The increase includes the following:

Built-in Increases (pay increases) - +$34,366,000

The provision of funds for pay increases for Federal and tribal employees are crucial if the system is to retain its employees. The retention of providers in rural health delivery organizations is critical. Since the salaries of health workers in urban environments is steadily rising, the out migration of employees to more lucrative urban and suburban jobs is threatening to leave rural health programs with very few over-worked providers and support staff. This reality has led to a vacancy rate of approximately 30 percent in dental staff and greater than 25 percent in pharmacy staff, and high vacancy rates in nursing and medical staff. Provision of appropriate and competitive salaries is critical to the operation of the system. The tribal and Federal programs are experiencing similar vacancy rates in critical positions.

Phasing-In of Staff for New Facilities - +$7,172,000 and 94 FTE

The request of $7,172,000 and 94 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**
Ft. Defiance, AZ Hospital	$1,079,000	14
Parker, AZ Health Center	6,093,000	80
Total	$7,172,000	94

Requests for additional amounts for staffing at Ft. Defiance, AZ and Winnebago, NE hospitals are under development.

Indian Health Care Improvement Funds - $8,000,000

The Indian Health Care Improvement Fund resources are used to address the variable needs of AI/AN communities. Because of historical appropriation and allocation events, there are inequalities in the availability of resources among AI/AN communities. The Congress recognizes these

disparities among communities and the disparity between the health of American Indians and Alaska Natives and the general population and authorized the funding of resources to address these differences.

Appropriations were provided in FY 2000 FY 2001. The agency distributed the FY 2000 funds on a non-recurring basis pending the completion of a major analysis on the relative level of funding available (level of Need study) to tribes requested by Congress. This study utilized standard actuarial methods to compare the availability of health resources for American Indians and Alaska Natives to the benefits available to Federal employees under the Federal Employee Health Benefits Program. This analysis revealed a more equitable approach to allocate the Indian Health Care Improvement Fund. The use of the Level of Need study information for the purposes of allocation of the Fund is currently under consultation with the tribes, but it is anticipated that its use in some form will be the basis for allocation of the Fund during FY 2001.

In FY 2000, the Fund was used to augment the available services provided through the hospitals and clinics. In general it was used to support non-recurring costs through purchased care (contract health care). It was allocated based on an assessment of need that was recognized as interim.

Information Technology - +$4,000,000: See Tab on page 137.

DENTAL HEALTH

Indian Health Service

Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2000 Est. +/- 2000 Actual	2002 Est. +/- 2001
Dental Health					
Budget Authority	$80,062,000	$91,018,000	$95,305,000	+$15,243,000	+$4,287,000
FTE	745	763	781	+36	+18
Total Patients Treated	300,000	328,000	335,000	+35,000	+7,000
Total Services Provided	2,400,000	2,487,000	2,509,000	+109,000	+22,000

PURPOSE AND METHOD OF OPERATION

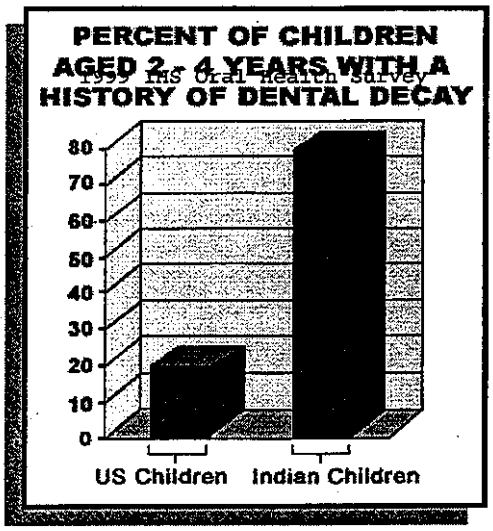
Program Mission and Responsibilities

The IHS Dental Program is committed to raising the oral health status of the AI/AN population to the highest possible level through the provision of high quality preventive and treatment services at the community and clinic levels. Despite a history of documented improvements in oral health status, the oral health of Indian people still lags well behind that of the overall population and this disparity may be increasing. For the past two years oral health problems have been identified by consumers participating in budget formulation activities among the top priorities for funding enhancement. As a result, oral health has been identified as one of the IHS Director's initiatives for FY 2001.

Between the early 1970s and the early 1990s, a period of overall dental program expansion, the IHS Dental Program made significant strides in improving the oral health of the AI/AN population. Results of the IHS-wide Oral Health Status and Treatment Needs Survey of over 25,000 dental patients completed in 1991 revealed several important findings. When compared with results from earlier monitoring surveys, a general decline in tooth decay among children and adults was detected. This encouraging trend can be attributed mainly to the extensive commitment that the IHS and local communities have made to water fluoridation during the past decade and the expanded use of dental sealant. However, AI/ANs continue to have substantially higher rates of dental caries and periodontal disease than the U.S. population at large.

Indian people are affected by dental disease at rates 2 to 10 times that of the overal U.S. population; for Indian patients with diabetes the disaparity is even greater.

Currently, access to dental care at IHS is below full capacity because of a dental workforce crisis: approximately 22 percent of the dentist positions in the IHS are vacant.



A follow-up oral health survey was initiated in FY 1999 to determine the current oral health status and continued or emerging problems that must be addressed. Approximately 13,000 patients participated in the survey in all 12 Areas. A final report will be available in spring 2001.

The IHS has been traditionally oriented toward preventive and basic care. More complex, rehabilitative care, although a legitimate need, is often deferred so the basic services may be provided to more persons. Within the Schedule of Services, a service priority hierarchy used by the Dental Program, over 90 percent of services provided is basic and emergency care. Estimates of demand for treatment remain high; however, a continuing emphasis on community health promotion/disease prevention is essential to long-term improvement in the oral health of AI/ANs.

In 1992, the IHS added a full-time national coordinator for dental health promotion/disease prevention to provide technical assistance to IHS and tribal programs. Because of the significant loss of support of dental health promotion/disease prevention available at the Area level due to tribal contracting and vacanies, the national coordinator has attempted to develop alternative networks including local I/T/U dental staff to carry on essential dental health promotion and disease prevention activities.

Tribal programs continue to exert a growing influence in the management of oral health programs. The number of tribally managed programs continues to grow steadily. Staff employed by or providing care in tribal programs produce over a third of the total direct dental services. To responsibly manage a health program requires data that supports an assessment of the health needs of the population. Tribal programs were well represented in the IHS 1991 Oral Health Survey of Indian patients and participated in the 1999 survey. Data gathered by these surveys provides tribes information from which to make rational decisions regarding their dental programs.

Best Practices/Industry Benchmarks

The IHS Dental Program has a long and distinguished history of serving as a benchmark of dental public health excellence. Beginning in the 1960s, the IHS Dental Program was a pioneer in developing dental resource planning

methods, and, in the early 1970's, published some of the first and most compelling findings regarding the efficiency and effectiveness of using expanded duty dental assistants in the provision of dental restorations.

Later in the 1970s, the IHS published what still remains as one of the most comprehensive and recognized approaches to quality assurance for dental care. In the 1980s and 1990s, the IHS Dental Program was recognized by winning three U.S. Public Health Service J.D. Lane research competitions for community based research/education projects as well as three American Dental Association awards for health promotion/disease prevention.

The program's Baby Bottle Tooth Decay Prevention Project, which won two of these awards, has been cited internationally as a model of community empowerment and program effectiveness. As part of these activities the IHS Dental Program collaborated with the World Health Organization, the Centers for Disease Control, the National Institutes of Health, the Head Start Bureau, and several universities.

But, undoubtedly, the ultimate benchmark of success for the public health organizations is what it accomplishes in term of positive outcomes for the people it serves. Based on analyses comparing findings from the most recent oral health survey completed in 2000, the results show, in comparison with the 1991 survey:

A **14 percent increase** in the number of children 5-19 years with no decay.

A **12 percent decrease** in the number of children 5-19 years with high decay rates (7 or more cavities).

A **21 percent increase** in the number of protective dental sealant placed on first and second molars in adolescent's ages 14 years.

A **9 percent increase** in the number of adults 35-44 years with periodontal disease (based on CPITN scores).

A **21 percent increase** in the number of adults 35-44 years who have never lost a tooth to periodontal (gum) disease or dental caries (cavities).

The Early Childhood Caries 5-year demonstration project will be evaluated in FY 01. The goals of this demonstration project are to reduce the percentage of young children with dental decay to 25 percent from baseline at each of the demonstration sites as well as to increase access to dental services by 25 percent at each site. Results of the demonstration will be shared program-wide in the summer of FY 2001.

ACCOMPLISHMENTS

The IHS dental program at Headquarters has been reorganized as the Division of Oral Health. Currently four professional and one administrative person comprise the staff that support a cadre of over 2500 dentists, dental assistants and hygienists in tribal and direct programs.

Specific accomplishments include:

- A workgroup has developed and is promoting clinical and community-based strategies to reduce the prevalence of early childhood decay. The strategies include providing a dental screening or exam by age one by medical and dental providers, teaching parents to brush their child's teeth and looking for early lesions that can be reversed with fluorides, and educating families about the disease process, diet and the importance of various fluorides.

- To reduce the prevalence of the dental decay, and increase access to care, a work group has developed a medical model of care that addresses dental decay as an infectious disease. Some of the key concepts are the importance of diagnosis of caries, assessing the risk of disease and applying the most appropriate preventive regimens and recall frequencies based on the individual patients needs and demands.

- National Oral Health Council composed of tribal and IHS clinical dental staff has been formed and have an approved charter. This group will provide a field perspective to issues facing the dental program.

- The Division of Oral Health has completed the oral health status and treatment needs survey of approximately 13,000 patients. A report will be completed in spring 2001 with the final analysis and program recommendations. Tribal and field input was solicited for the report.

- The IHS, National Institutes of Dental and Craniofacial Research, and State University of New York at Buffalo continue to collaborate on the treatment of periodontal disease in persons with diabetes. The initial clinical trial conducted in the Phoenix Area demonstrated the effectiveness of a non-surgical treatment regimen. The project is currently being replicated in the Albuquerque Area. Three 5-year grants were awarded in FY 1998 and three awards will be made in FY 2001 to help IHS, tribal, and urban programs incorporate this technology into their dental programs.

- The Division of Oral Health has developed a process for awarding resources to tribes and Areas to help build the public health infrastructure and capacity through dental clinical and preventive support centers. In FY 2000, four tribal programs were awarded resources to demonstrate unique strategies to provide training and technical assistance to programs within their geographic areas. In FY 2001, up to three additional tribal/Area programs will be awarded.

- The Division of Oral Health continues its efforts to support tribal community water fluoridation programs. In its second year of a three-year inter-agency agreement with the Centers for Disease Control and Prevention (CDC), strategies are being developed to support small water systems to effectively maintain optimal levels of fluoride in their water in order to assure the dental benefits. The Albuquerque and Phoenix Areas are part of the demonstration and have shown a 38 percent increase in water fluoridation compliance from FY 99 to FY 2000.

- Strategies to recruit and retain more dentists in the IHS have been implemented to include an interactive website, promoting civil service Title 38 for dentists, and an expansion of program dollars for loan

repayment. The vacancy rate has declined from 25 percent to 22 percent during the past fiscal year.

PERFORMANCE MEASURES

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to achieve the following:

Indicator 11: During FY 2002, increase the proportion of compliant water utilities serving AI/AN people with optimally fluoridated water by 10 percent over the FY 2001 levels for all IHS Areas.

Indicator 12: During FY 2002, increase the proportion of the AI/AN population who obtain access to dental services by 1 percent over the FY 2001 level.

Indicator 13: During FY 2002, increase the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth by 1 percent over the FY 2001 level.

Indicator 14: During FY 2002, increase the proportion of the AI/AN population diagnosed with diabetes that obtains access to dental services by 2 percent over the FY 2001 level.

Indicator 15: During FY 2002, reduce the rate of untreated dental decay in children 6-8 year and 14-15 year by 2 percent from the level documented in the IHS 1999-2000 oral health survey.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$65,517,000	861	
1998	$65,517,000	818	
1999	$71,400,000	763	
2000	$80,062,000	745	
2001	$91,018,000	763	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $95,305,000 and 781 FTE is an increase of $4,287,000 and 18 FTE over the FY 2001 enacted level of $91,018,000 and 763 FTE. The increases are as follows:

Built-in Increases: +$2,842,000

The request of $397,000 for inflation/tribal pay cost and $2,445,000 for Federal personnel related cost would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service for American Indian and Alaska Natives. Maintaining the current

I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$1,445,000 and 18 FTE

The request of $1,445,000 and 18 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities	Dollars	FTE
Parker, AZ Health Center	$1,445,000	18

MENTAL HEALTH SERVICES

Indian Health Service

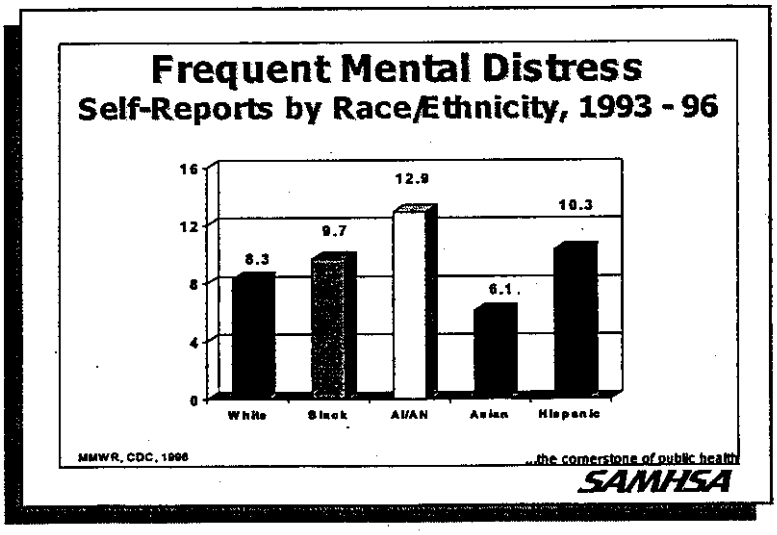
Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Mental Health					
Budget Authority	$43,245,000	$45,018,000	$47,142,000	+$3,897,000	+$2,124,000
FTE	283	297	303	+20	+6
Total Client Contacts	208,000	208,000	208,000	0	0

PURPOSE AND METHOD OF OPERATION

PROGRAM MISSION AND RESPONSIBILITIES

The IHS Mental Health and Social Services (MH & SS) program is a community oriented clinical and preventive service program. The programs and services provided are a part of a larger Behavioral Health Program that includes the Alcoholism and Substance Abuse Program. This collaborative effort addresses 4 of the top 10 health issues as identified conjointly by the IHS, Tribes, and Urban Programs (I/T/U) including behavioral health issues, domestic violence, child abuse and neglect, and alcohol and substance abuse disorders. American Indian and Alaska Native (AI/AN) communities possess considerable traditional and cultural resources; however, the level of psychosocial and emotional distress is alarmingly high.

The improvements in physical health status for AI/AN populations have not been paralleled in the mental health and social services area. Field staff report serious mental and social problems in many AI/AN communities on reservations and in urban settings.

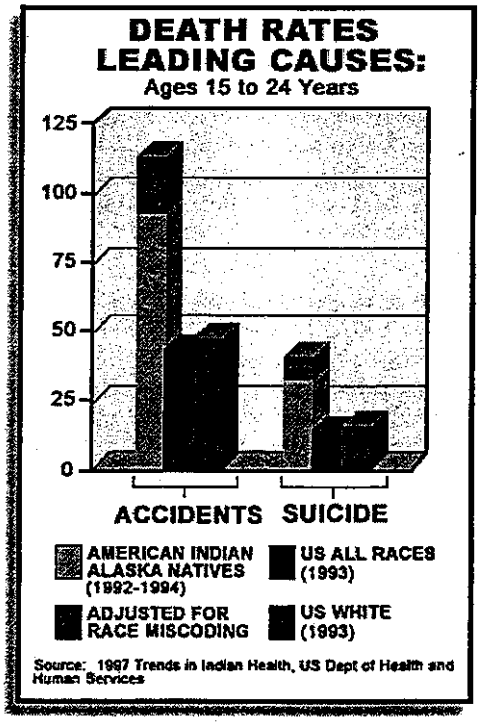


Studies indicate that mental health and social problems are associated with more than one-third of the demands made on health facilities for services. Depression, anxiety, and post-traumatic stress disorder are emotional problems that are reported frequently in IHS patient care data. Corroborating data from the Substance Abuse and Mental Health Services Administration (SAMHSA) depicted in the graph below and shows that

AI/ANs have the highest rates of mental distress of all ethnic and racial groups.

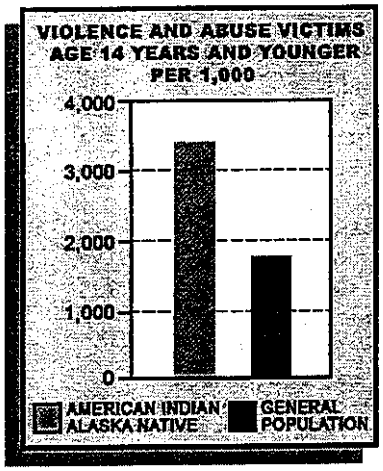
The overall suicide rate for the AI/AN population is approximately 72 percent higher than the national rate.

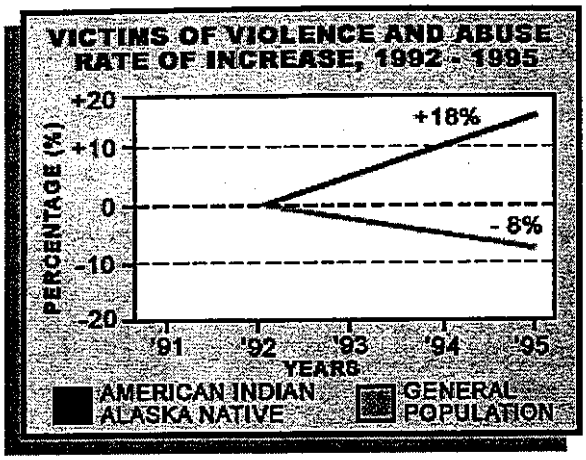
- The highest suicide rate is found in AI/ANs aged 15-34 as compared with the general population where the highest suicide rate is found for individuals aged 74 and older. The suicide rate for AI/AN males aged 15-34 is approximately 2.4 times the national rate or about 60 deaths per 100,000 populations. AI/ANs represent the fastest growing ethnic group in the U.S.; the median age is 27.8 years, approximately 8 years younger than that of the general population. AI/AN deaths due to accidents are approximately 3 times the rate for the general population. Many health professionals consider a substantial portion of deaths reported as accidents or injuries actually to be suicides. These data point to potential significant cultural, social, and economic impact for AI/AN people. These facts point to the severity of mental health problems in AI/AN communities.



- The rates of violence for every age group are higher among AI/ANs than that of the general population. Statistics point to a considerable problem of violence perpetrated both by and against AI/AN youth. The rate of violence for AI/AN youth aged 12-17 is 65 percent greater than the national rate for youth. Gang membership is increasing within urban as well as reservation/rural communities. Seventeen percent of AI/ANs arrested for violent crimes are under the age of 18.

The rate of homicide in AI/AN communities is 41 percent higher (approximately 15.1 per 100,000) than the national rate. The greatest numbers of homicides occur in AI/AN males ages 15-44 and reaches nearly 40 deaths per 100,000 (2.7 times greater than the aggregate AI/AN population homicide death rate).





- Domestic violence and childhood sexual abuse are reported at alarming rates in AI/AN country. The homicide mortality rate for American AI/AN female ages 25 to 34 years is about 1.5 times that for the general population of females in this age group.

- Over crowding in homes, lack of housing, and other socioeconomic issues are associated with these high rates of abuse and neglect. Higher rates of lethal aggression are found among economically impoverished communities; the number of AI/AN families who are at or below the poverty level is 25.9 percent, a number significantly higher than for the general population. Over 75 percent of family violence victims report that the perpetrator had been drinking at the time of the offense as compared to approximately 49 percent for the general population.

- Problems of alcohol abuse, depression and anxiety frequently underlie and complicate treatment for physical disorders and traumatic accidents, requiring considerable attention from caregivers. Alcoholism death rates are approximately 6.7 times the national rate; this is approximately 40 per 100,000 for the AI/AN population versus 5.9 for the general population. Liver disease, cancer diabetes mellitus, heart disease, cerebrovascular disease, as well as other diseases occur in significantly higher proportions in AI/AN communities as compared to the general population. The impact of chronic health problems on psychological well being, particularly depression and suicidal ideation, has significant implications for AI/AN individuals, families, and communities. Please refer to the Alcoholism and Substance Abuse Program narrative for additional information about substance abuse concerns.

The most common MH/SS program model is an acute, crises-oriented outpatient service staffed by one or more mental health professionals. On-call emergency mental health services are also provided outside of usual clinic or hospital hours. Medical and clinical social work are usually provided by one or more social workers to assist with discharge planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling. Completing priorities over existing resources and difficulties recruiting trained specialists lead to limited provision of specialized mental health services for populations such as children and the elderly. BIA, state or local community agencies may also provide supportive services to AI/AN persons with emotional problems. Virtually no partial hospitalization, transitional living, or child residential mental health programs exist in IHS or tribal operations, these

services are obtained from local or state resources when available. Inpatient services are provided under contract with local general hospitals psychiatric units or private psychiatric hospitals. Emergency and long duration hospitalizations are generally provided by state mental hospitals. Such hospitals rarely consider cultural needs or offer culturally relevant services such as including traditional healers in the healing process.

Many critical components of mental health, child abuse and social service programs, such as day programs, suicide prevention, and child abuse victim treatment are not available to AI/AN communities. The IHS continues to emphasize community wide intervention and prevention strategies in collaboration with tribes with the goal of improving long term health for child and family based problems. Prevention and early intervention, although legitimate needs, are often deferred so that crisis intervention may be provided to a greater number of clients.

Traditional healers are utilized in most AI/AN communities. At the option of individual tribes, traditional medicine is coordinated with other health and mental health services. Traditional healing practices are important health resources in AI/AN communities.

Services available to AI/AN communities for serious mental health and social problems continue to be limited.

There is approximately 1 psychologist per 8,333 AI/ANs as compared to 1 per 2,213 for the general population.

Most service units and tribal programs are operated with little backup because of the rural and isolated nature of their practice. Professional turnover and burnout also affect the availability of services. In addition to the relatively low numbers of mental health professional available to provide services for AI/AN communities, researchers also suggest burnout is related to secondary traumatic stress - the effect that hearing about and dealing with other's trauma has on the mental health professional.

ACCOMPLISHMENTS

Accomplishments of the Mental Health/Social Services Program include the following:

Children's Mental Health

Significant programmatic activities include:

- Grants to support tribal child abuse and family violence prevention programs and day treatment for mentally ill persons. Other support for child abuse prevention includes providing training to IHS and tribal providers in cooperation with the University of Oklahoma and the University of New Mexico. Joint efforts with the BIA on conducting background checks for tribal, IHS and BIA programs, and joint collaborations with the DOJ and tribes on developing community-based

prevention/intervention initiatives for adolescent sexual abuse perpetrators.

- Continuation of a $2.4 million AI/AN children's mental health initiative with SAMSHA.

- Joint efforts with the Head Start Bureau that provide health and mental health consultation and training to 152 AI/AN Head Start and Early Head Start programs including family violence prevention and intervention.

- Reestablished the National Child Protection workgroup, an interagency collaboration with the BIA, DOJ, and IHS. This group developed a child protection manual to educate and inform individuals working in AI/AN communities about child protection laws, indicators, and reporting procedures.

- Developed a Child Sexual Abuse Examination Training and Telemedicine Project in collaboration with OVC. This project provides colposcopes and auxiliary equipment as well as training, consultation, and technical support for medical practitioners.

- Continued the Indian Children's Program at full funding for another year. This provides a stronger focus on early identification and intervention with disabled children and their families.

- Training regarding the needs of high risk children and youth includes: the detection and intervention for emotionally disturbed youth and child abuse victims in BIA boarding schools; residential treatment centers (RTCs); tribal detention centers; and the Juvenile First Offender Diversion Program training in AI/AN communities with the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

Major Partnerships

Major partnerships currently exist with Bureau of Indian Affairs (BIA), Substance Abuse and Mental Health Service Administration (SAMHSA), Center for Disease Control (CDC), Department of Justice (DOJ) and Administration for Children and Families (ACF).

- Developed a federal and non-federal interagency AI/AN Youth Violence workgroup for the purpose of information dissemination and education.

- Participation in multi-agency Area Child Protective Teams. These teams are designed to ensure communication, cooperation, and follow-through with neglect/abuse cases.

- Collaboration with the BIA, DOJ, CDC, as well as other national, state, and local agencies in providing training and consultation to I/T/U providers about domestic violence, child abuse, and elder abuse. Also, an IHS system wide identification and intervention for victims of domestic violence will continue in the I/T/U health facilities.

- Participated in a number of interagency activities, such as meetings and workgroups, with SAMHSA, the Office of Justice Juvenile Detention Program, and the National Center for Child Abuse and Neglect, and the BIA that has positively impacted services for AI/AN communities.

- Renewed several interagency agreements that have resulted in increased resources for AI/AN communities. These include agreements with: (a) the Office of Victims of Crime to provide funds to IHS for Child Protection Team Training; (b) SAMHSA to support an AI/AN Technical Assistance Center for the nine AI/AN grantees selected for the Circles of Care Children's Mental Health Initiative and to the three AI/AN Children's Mental Health Service grantees; (d) the Office of Child Abuse and Neglect to continue support of Project Making Medicine at the University of Oklahoma which provides training in child abuse treatment to IHS and Tribal mental health, social service, and substance abuse providers and training and technical assistance to their communities. This project also provides training and technical assistance to the American Indian Program Branch/Headstart grantees.

- Co-facilitated a BIA, DOJ, IHS interagency Indian Country Detention Summit to promote collaboration of law enforcement and behavioral health in providing expanded health services to adjudicated adults and juveniles.

- Continued implementation of suicide prevention strategies in collaboration with CDC including development of a tribally based national suicide prevention network/center.

- Provided mental health training and program consultation to eleven adolescent Regional Treatment Centers. See Alcoholism and Substance Abuse narrative for additional information.

- Funded eight 3-year Mental Health and Community Safety Initiative grants. This represents the IHS portion of a collaborative effort with DOJ, BIA, DOE, and SAMHSA providing over 5 million total in grants to AI/AN communities each year.

Training and Development

Training and development remain priorities not only to help existing staff keep current of advancements in treatment and prevention, but as a means to recruit behavioral health care providers into AI/AN communities.

- Continued the Social Work Fellowship Program with the University of New Mexico that provides child-specific training for AI/AN professionals.

- Continued the Southwest Consortium Pre-doctoral Psychology Internship program that provides training for one intern. This intern provides direct psychological services in the IHS Albuquerque Service Area; AI/AN preference is given to this position.

- Continued funding for the Annual Conference for Psychologists and Psychology students, a forum for students to present their research, develop mentorship relationships, and for I/T/Us to recruit mental health and social service providers.

- Developed and provided a national Behavioral Health Conference for I/T/U behavioral health providers, administrators, and other interested parties. Federal partners were invited to participate as well as grantees.

Data Collection

- Expansion of the MH/SS system in the I/T/U facilities for mental health data collection including suicide, child abuse, and domestic violence in addition to other clinical information. Data for baseline morbidity are essential to fully support the I/T/U planning and management of health programs.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At this funding level, IHS could achieve the following:

Indicator 16: During FY 2002 the IHS will assure that:

a. At least 82 percent of I/T/U medical facilities (providing direct patient care) will have written policies and procedures for routinely identifying and following:
   - Spouse/intimate partner abuse
   - Child abuse and neglect
   - Elder abuse or neglect

b. At least 56 percent of I/T/U medical facilities will provide training to the direct clinical staff on the application of these policies and procedures.

Indicator 18: During FY 2002, increase the number of I/T/U programs utilizing the Mental Health/Social Services (MH/SS) data reporting system by 5 percent over the FY 2001 rate.

Indicator 27: During FY 2002, increase by 10 percent over the FY 2001 level, the proportion of I/T/Us that have implemented systematic suicide surveillance and referral systems which include:

a. Monitoring the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions)
b. Assuring appropriate population-based prevention interventions are implemented and those identified at risk receive services

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$38,341,000	311	
1998	$39,379,000	308	
1999	$41,305,000	290	
2000	$43,245,000	283	
2001	$45,018,000	297	Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $47,142,000 and 303 FTE is an increase of $2,124,000 and 6 FTE over the FY 2001 enacted level of $45,018,000 and 297 FTE. The increases are as follows:

Built-in Increases: +$1,590,000

The request of $514,000 for inflation/tribal pay cost and $1,076,000 for federal personnel related costs would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service for American Indians and Alaska Natives. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$534,000 and 6 FTE

The request of $534,000 and 6 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities	Dollars	FTE
Parker, AZ Health Center	$534,000	6
Total	$534,000	6

ALCOHOL & SUBSTANCE ABUSE

Indian Health Service

Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Alcohol & Substance Abuse					
Budget Authority	$96,824,000	$130,254,000	$135,005,000	+$38,181,000	+$4,751,000
FTE	172	172	172	0	0
Services Provided:					
Outpatient Visits	590,000	750,000	750,000	+160,000	0
Inpatient Days	285,000	365,000	365,000	+80,000	0
Regional Trt Center:					
Admissions	3,700	4,700	4,700	+1,000	0
Aftercare Referrals	8,700	11,100	11,100	+2,400	0
Emergency Placements	390	500	500	+110	0

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

The Alcoholism and Substance Abuse Program (ASAP) activities are part of a Behavioral Health Team that works collaboratively to eliminate the disease of alcoholism and other drug dependencies and the associated pain it brings to individuals of all ages, families, villages, communities, and tribes. The ASAP primary goal is to reduce the prevalence and incidence of alcoholism and other drug dependencies. The ASAP provides support and resources for AI/AN communities toward achieving excellence in holistic alcohol and other drug dependency treatments, rehabilitation, and prevention services for individuals and their families. In addition to the development of curative, preventative and rehabilitative services, the ASAP activities include:

- Development and coordination of an integrated information management system that measures substance abuse and alcohol problems among AI/AN;
- Programmatic evaluation and research toward developing effective prevention and treatment services;
- National leadership that focuses on youth treatment, community education, and prevention services for high-risk youth; and
- Services for children and adults with FAS and FAE.

The ASAP continues to provide services primarily through contracts with tribal entities/consortia, including tribes that have compacted under Self-Governance, and Indian-managed urban boards of directors since the passage of the Indian health Care Improvement Act, P.L. 94-437. Presently, the IHS funds approximately 300 AI/AN ASAPs that provide a multitude of treatment and prevention services to rural and urban communities.

funds approximately 300 AI/AN ASAPs that provide a multitude of treatment and prevention services to rural and urban communities.

Best Practices/Industry benchmarks

Approximately 5 percent of the estimated 1,800 employees in IHS-funded ASAPs are Federal staff with Tribal staff comprising 95 percent. The credentialing, training, and hiring of 1,200 counselors have been a major initiative to address counselor competency. The counselor certification and professional licensure rates continue at approximately 85 percent of the program staff.

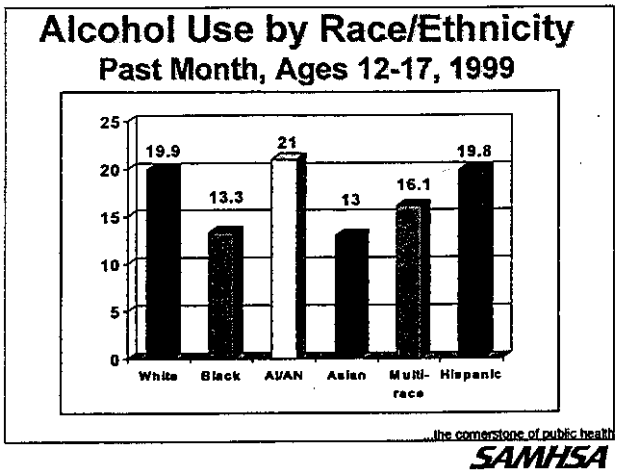
There are four YRTCs accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) and four others that are accredited by Commission on Accreditation of Rehabilitation Facilities (CARF). Two of the three remaining facilities are state licensed/certified, and one of the facilities is currently preparing for CARF accreditation.

The tribal alcohol programs are state licensed and/or certified. The majority of the tribal alcohol programs follow the Indian Health Manual, Part III, Chapter 18, ASAP Standards that are modeled after JCAHO and CARF Standards.

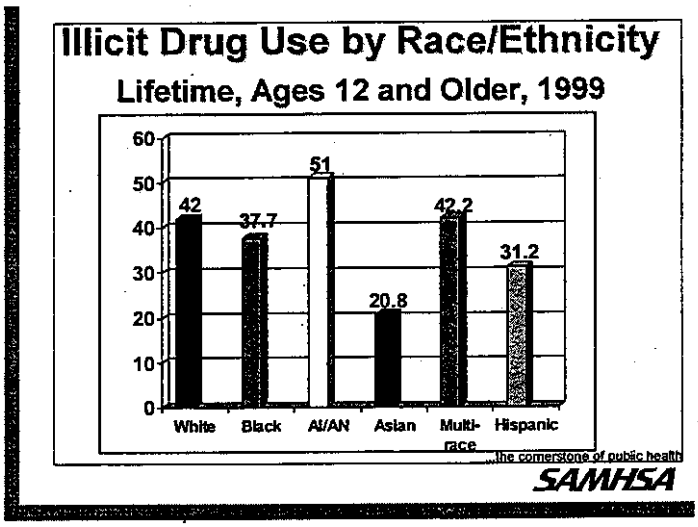
Correcting identified areas for improvement in residential and non-residential facilities requires additional resources to improve alcoholism and substance abuse programs. For example, an evaluation of the effectiveness of IHS sponsored aftercare/continuing care service is an underway though other program efforts remain to be evaluated when resources allow.

Findings Influencing FY 2002 Request

Alcoholism mortality for AI/ANs decreased from 59 per 100,000 in 1980 to 37.9 per 100,000 in 1991. The latest data, however, indicate that alcoholism mortality rates have worsened since 1992. When the 1992-1994 alcoholism death rate is adjusted for miscoding of Indian race on death certificates, it increases from 39.4 per 100,000 to 45.5 per 100,000, nearly 7 times the alcoholism death rate of the overall U.S. population. Similarly, the age-adjusted drug-related death rate for AI/ANs increased from 3.4 deaths per 100,000 in 1979-1981 to 5.3 in 1992-1994. The AI/AN drug-related death rate is 18 percent higher than the rate for the overall U.S. population. In an evaluation study of the Youth Regional Treatment Centers (YRTC), problem severity in AI/AN youth appears to be more treatment intensive in comparison to the general U.S. population as indicated by program completion rates of 53 percent versus 61 percent of the general population. Comprehensive care requirements favor dually trained staff in mental health and alcohol/substance abuse disorders to effectively and safely meet the needs of young people with dual diagnosis.

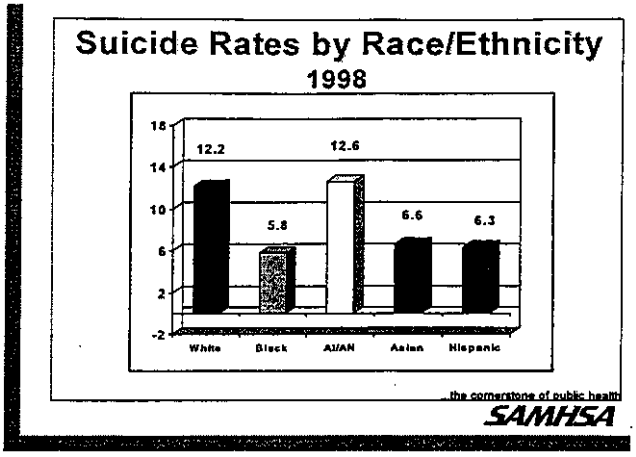


The 1999 Substance Abuse and Mental Health Services Administration (SAMHSA) data show that compared to all races and ethnic groups, AI/ANs Ages 12-17 have the highest alcohol use rates (Past Month).



Data for 1999 show that AI/ANs have the highest lifetime illicit drug use for ages 12 an older compared to all races and ethnic groups.

The high rates of alcohol and illicit drug use are significant as independent issues but alarming when joined with high suicide rates, as reflected in SAMSHA data for 1998 by race and ethnicity.



ACCOMPLISHMENTS

Interagency Activities

The IHS Alcoholism and Substance Abuse Program (ASAP) collaborated with Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), Health Care Finance Administration (HCFA), Bureau of Indian Affairs (BIA), Housing and Urban Development, Department of Transportation, and the Department of Justice (DOJ).

- Local community based training workshops and events called "Gathering of Native Americans," are being widely adapted throughout Indian Country. These workshops and events have been designed, tested, and evaluated in American Indian communities with the help of Indian education, social services and health professionals supported by both the IHS and the SAMHSA Center for Substance Abuse Prevention (CSAP). These workshops have revitalized community planning interest and capabilities for addressing alcoholism and substance abuse.

- Coordination with the Centers for Disease Control and Prevention to fund an injury management control officer and a tobacco education and training officer.

- Two IHS ASAP staff members work two days per week within the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP) respectively. This cooperative effort has increased national consultation and collaboration for AI/AN behavioral health specifically around access to services through state block grants and competitive grant opportunities.

- Numerous clinics and hospitals in the Aberdeen Area are using the CDC developed Prenatal Health Assessment screening instrument for pregnant substance abusing women.

- IHS continues to fund Fetal Alcohol and Drug Unit mini-internships at the University of Washington for I/T/U providers.

- IHS worked with the Office of National Drug Control Policy, the Department of Transportation, Bureau of Indian Affairs, Department of Justice, and the Housing and Urban Development to co-sponsor and develop an Annual National Tribal Leaders Best Practices Substance Abuse Summit

in. The first summit occurred last year and plans are currently underway for a continuation of this activity.

Professional Development

- The IHS continues to support primary care provider training workshops to enhance professional skills in addiction, prevention, intervention, and treatment. A special module has been developed for public health nurses. Between 40 to 60 primary care providers receive this training each year Activities include the development of a lending library (video and slide materials) to improve provider in-service capability and community presentations.

- Counselor certification and professional licensure rates continue at approximately 85 percent of the program staff. New funding will be used, in part, to improve the rate of licensure and/or certification for IHS-funded ASAPs.

- Clinical supervision/training continues as in previous fiscal years to enhance counseling efforts.

Information Management

- Plans are underway to merge the Chemical Dependency Management Information System (CDMIS) with the Social Services and Mental Health reporting system. The data merger will provide more information on the full range of behavioral health issues facing the AI/AN people. Funds available in 2001 are being used to initiate data merger activities including assessment, equipment, and training.

- Previous CDMIS data management activities integrated commercial and RPMS data facilitating a behavioral health treatment model. The integrated data system is being tested in the Billings Area. The ASAP is supporting two software enhancement projects that further integrate and coordinate assessment, treatment planning, and case management utilizing the American Society of Addiction Medicine (ASAM) Patient Placement criteria and the CSAT Alcohol Severity Index (ASI). Systems are being tested at 10 YRTCs and in the Billings Area.

Fetal Alcohol Syndrome

- Leadership is being provided for the prevention of secondary disabilities in FAS individuals. While comprehensive data are not available, studies suggest that alcohol affected pregnancies are at least 10 times more frequent in AI/AN communities than in the broader population. A training manual was prepared in conjunction with the Jamestown S'Klallam Tribe for providers, parents, and caregivers of FAS children and adolescents. The IHS is responding to a high volume of requests for the manual as resources on FAS/FAE, particularly for AI/ANs, which are currently scarce.

- Funds were provided early in FY 2001 from a congressional earmark for SAMHSA to administer through the Center for Substance Abuse Prevention for an FAS/FAE project. The funds were awarded to a four-state consortium that includes Montana, North Dakota, South Dakota and Minnesota. Each state within the consortium is working on a state-

specific FAS/FAE plan. Over the next 2-3 years the consortium states will work together to identify high-risk populations, test interventions, and collect data. All citizens in the four states are a part of the target population, however, specific high-risk groups will be identified. It is expected that AI/ANs will figure into the high-risk populations for FAS/FAE.

Treatment for Women

- The IHS ongoing effort to evaluate alcohol and substance abuse treatment for AI/AN women resulted in a final report, dated, January 2001. The evaluation indicates that alcohol and substance abuse accounts for 25 percent of the deaths for AI/AN women and defines factors critical to successful treatment. Childcare is a significant factor in the alcohol treatment of AI/AN women. Plans are underway in IHS to address childcare and women's treatment in concert with the BIA.

Future Directions

The IHS actively cooperates with DHHS, and other agencies in developing policy research agendas, and data monitoring. The IHS seeks to reduce alcohol and drug abuse by using strategies that include:

- Continue implementation of a planned integration of RPMS and standardized commercial behavioral health software to enhance the treatment plans, evaluation of services, and improve third party reimbursement. Because the value of the information and data that would result from this effort is significant, it has been determined as the Behavioral Health priority.

- Research and evaluation of collaborative efforts and after-care evaluation.

- Continue development of a comprehensive continuum of care encompassing prevention, education, treatment and rehabilitation. Workshops on American Society of Addiction Medicine Patient Placement Criteria will be continued.

- Continue to support treatment and prevention for women and men.

- Support inhalant abuse prevention and treatment initiative as a gateway drug in children, including Head start, and young adolescents.

- Injury control projects, e.g., the DHHS' Healthy People 2010 objectives.

- Continue efforts in enhancement of counselor skills.

- Tobacco cessation programs.

- Expand primary prevention efforts via collaboration with the Center for Substance Abuse Prevention and other agencies.

- Coordinate with the BIA to work with the Tribes to review and update community plans and action items that address alcohol and substance abuse issues.

- Continue to work with States and other Federal agencies to assist Tribes in accessing available competitive grants that are effective in the AI/AN communities.

- Expand on previous work to determine resources needed to provide behavioral health services (an integrated model of mental health and substance abuse/alcohol programs).

- Expand on traditional healing efforts that are showing increasing benefit in many AI/AN communities.

- Continue enhancement of YRTCs development and effectiveness.

- Continue to enhance and improve aftercare services available to youth.

- Continue meetings to address the national adolescent inhalant abuse issue.

Participate with CSAT and the Administration for Children and Families to conduct four regional meetings for child welfare and substance abuse issues. Continue IHS/CSAP initiatives with Tribal Colleges and Universities and the three-year, tri-state FAS/FAE project in the Billings, Aberdeen, and Bemidji Areas. Expand the IHS Elder Care Initiative by broadening the assessment of AI/AN elders to include alcohol and substance abuse assessments.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representing the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to achieve the following:

Indicator 9: During FY 2002, youths discharged from Regional Treatment Centers (RTC) will:

a. Receive follow-up equal to or greater than the FY 2001 level

b. Increase by at least 5 percent over FY 2001, the youths who have documented 6 months of less alcohol and drug use than before treatment

Indicator 10: During FY 2002, increase the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 5 percent over the FY 2001 level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$91,482,000	184	
1998	$91,782,000	186	
1999	$94,680,000	175	
2000	$96,824,000	172	
2001	$130,254,000	172	Enacted

In H.R. 5666, "Miscellaneous Appropriations", as Actual by the Consolidated FY 2001 Appropriations Bill (HR 4577), Congress made a $15 million direct lump sum appropriation to the Alaska Federation of Natives (AFN) for its "Alaska Native Sobriety and Alcohol Control Program" that allows the AFN to make grants to each of the regional Alaska Native corporations to ban the sale, importation, and possession of alcohol pursuant to local option state law. An additional 15 million is provided to the IHS for the non-Alaska Tribes for drug and alcohol prevention and treatment services. A portion of the funds will be used to support the data consolidation project. The remainder of the funds will be distributed to each of the Areas to spend on alcohol and substance abuse priorities. These activities are continued in FY 2002.

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $135,005,000 and 172 FTE is an increase of $4,751,000 over the FY 2001 enacted level of $130,254,000 and 172 FTE. The increase includes the following:

Built-in Increases: +$4,751,000

The request of $4,255,000 for inflation/tribal pay cost and $496,000 for federal personnel related costs funds the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service for American Indians and Alaska Natives. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

ALCOHOLISM AND SUBSTANCE ABUSE PREVENTION/TREATMENT PROGRAM AUTHORIZED UNDER P.L. 103-572
(DOLLARS IN THOUSANDS)

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation**	FY 2002 Request
Adult Treatment	$47,232	$49,566	$51,693	$51,693	$51,766	$51,936	$53,576	$54,789	$65,299	$67,681
Regional Treatment Centers	12,407	14,040	14,013	14,013	14,033	14,079	14,523	14,852	20,378	21,121
Community Education & Training	2,594	2,726	2,880	2,880	2,884	2,894	2,985	3,053	11,370	11,784
Community Rehabilitaiton/ Aftercare	11,880	13,593	15,088	15,088	15,109	15,159	15,638	15,992	24,776	25,680
Gila River		135	135	135	135	136	140	143	148	154
Contract Health Service	5,920	6,221	6,209	6,209	6,218	6,238	6,435	6,581	6,819	7,067
Navajo Rehab. Program	237	249	239	239	239	240	248	253	262	272
Urban Clinical Services	450	473	509	509	510	511	528	539	559	579
Wellness Beyond Abstinence	585	614	586	586	587	589	607	621	644	667
Total	$81,305	$87,617	$91,352	$91,352	$91,482	$91,782	$94,680	$96,824	$130,254	$135,005

URBAN HEALTH PROGRAM 1/

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation	FY 2002 Request
Expand Urban Programs	2,828	2,972	3,044	3,045	3,045	3,048	3,180	3,239	3,367	3,491

INDIAN HEALTH FACILITIES 2/

Amount of Funds	FY 1993 Appropriation	FY 1994 Appropriation	FY 1995 Appropriation	FY 1996 Appropriation	FY 1997 Appropriation	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Appropriation	FY 2002 Request
Construction	7,929	2,780	0	0	0	0	0	0	0	0

Alcohol/Substance Abuse	**$81,305**	**$87,617**	**$91,352**	**$91,352**	**$91,482**	**$91,782**	**$94,680**	**$96,824**	**$130,254**	**$135,005**
Urban Health Program	**2,828**	**2,972**	**3,044**	**3,045**	**3,045**	**3,048**	**3,180**	**3,239**	**3,367**	**3,491**
Facilities Construction	**7,929**	**2,780**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**$92,062**	**$93,369**	**$94,396**	**$94,397**	**$94,527**	**$94,830**	**$97,860**	**$100,063**	**$133,621**	**$138,496**

**These amounts are subject to change as the distribution of the additional $30 million appropriated under Labor, HHS is pending consultation and approval by the Tribes.

1/ The Urban Program was funded under P.L. 100-690, and now is funded under P.L. 103-572.

2/ These funds included in the Outpatient Sub-sub-activity.

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CONTRACT HEALTH SERVICES

Indian Health Service

Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Contract Health Services					
Budget Authority	$406,756,000	$445,773,000	$445,776,000	+$39,020,000	+$3,000
Gen. Med & Surg. Hospitalization: ADPL	248	252	248	0	-4
Ambulatory Care: Outpatient Visits	490,700	541,600	507,305	+16,605,000	-34,295
Patient & Escort Travel: One Way Trips	35,900	39,600	37,007	+1,107	-2,593
Dental Services	60,600	66,900	61,678	+1,078	-5,222

PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

The IHS Contract Health Services (CHS) program supplements the health care resources available to eligible American Indian and Alaska Native (AI/AN) people with the purchase of medical care and services that are not available within the IHS direct care system. The IHS purchases both basic and specialty health care services from local and community health care providers, including hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services such as ground and air ambulance. The CHS program also supports the provision of care in IHS and tribally operated facilities, such as specialty clinics, e.g., orthopedics and neurology, and referrals to specialists for diagnostic services.

The CHS program is administered through 12 IHS Area Offices that consist of 66 IHS-operated Service Units and 84 tribally operated health programs. Although the IHS facilities include two major medical centers, and one tribally medical center most of the IHS and tribally operated facilities are small rural community hospitals and health centers with basic primary care services. In addition, not all tribes have access to IHS or tribally operated facilities or have limited access. Therefore, those Areas with few or no direct care facilities have a higher reliance on the CHS program to provide the needed health care.

The CHS budget includes a Catastrophic Health Emergency Fund (CHEF) of $15,000,000 in FY 2001 which was increased by $3 Million from the previous year and is intended to protect local CHS operating budgets from overwhelming expenditures for certain high cost cases. To access the

FY 2000 $12 million CHEF program, a threshold of $20,100 established by the annual change in the consumer price index as mandated by congressional legislation must be first met. Once the threshold was met, the $12 million CHEF budget for FY 2000 provided funds for more than 800 high cost cases in amounts ranging from $1,000 to $600,000 per case. The FY 2002 Budget continues CHEF at $15,000,000.

Best Practices/Industry Benchmarks

Because of high patient demand, the IHS relies on strict adherence to specific CHS guidelines to ensure that the most effective use of CHS dollars is attained. As much as possible, the IHS pursues negotiated rate agreements with private health care providers to obtain health care at reduced rates, including managed care arrangements. In addition to the CHS requirement for eligibility, the IHS utilizes a medical priority system and is considered to be the payer of last resort. This means that all alternate resources that a patient is eligible for must be first exhausted, before the IHS can pay. Tribal contractors generally provide services under the same CHS regulations as the IHS.

In addition, the IHS fiscal intermediary (FI) contract with Blue Cross/Blue Shield of New Mexico provides a mechanism of payment to services in the private sector. The FI ensures that payments are made accurately and timely according to contractual requirements where applicable, and maintains a centralized medical and dental claims reimbursement system. The FI process functions within the IHS payment policy and meets the standards of the medical industry. In addition to providing payments to vendors, the FI provides program support services that collects, compiles, organizes workload, and financial data, and generates statistical reports to the IHS that support the administration of CHS programs.

Findings Influencing FY 2002 Request

Increased costs for professional care services:

- According to the Bureau of Labor Statistics, the Consumer Price Index for Medical Care increased 3.6 percent between 1998 and 1999, whereas for professional care services the IHS FI reported an increased cost of 5.83 percent for 1999.

ACCOMPLISHMENTS

In FY 2001, the CHS program received a significant increase of $40 Million. The additional funds increased the CHEF budget by $3 Million and increased the CHEF program from $12 million to $15 million; approximately $2 Million was used to fund new tribes. The balance of the increase was shared with the Area Title I and Title III tribes, as well as with the Area IHS programs to provide more needed health care. Health care issues such as equity funding, health disparities as well as deferrals and denials, large cost increases associated with professional contracts, and dental are now beginning to be addressed. The CHS program continues to support the provision of care in IHS and tribally operated facilities, as specialty clinics, orthopedics, neurology and referrals for specialty services.

In addition, IHS patients are able to receive more health care services than the amount of CHS expenditures indicate. This is accomplished through a variety of mechanisms such as maximizing alternate resource requirements,

and continuing to pursue provider discounts/contracts. Alternate resource (AR) means other third party payers must pay before the IHS will pay. To accomplish this patients are required to inform the Service what type of AR they have and must apply if they are potentially eligible for an AR. Examples of an AR include private insurance, Medicare, and Medicaid.

Provider discounts/contracts are agreements to reimburse health care providers at an amount below billed charges. Types of provider reimbursement contracts at a discount include, payment using Medicare methodology, a percent of Medicare methodology, per diem rates, and percent of billed charges (if less than Medicare).

Because of the procedures described above, the CHS program has been able to purchase health care services that total more than twice the amount of the CHS expenditures. The actual amount of billed charges purchased through these arrangements cannot be completely documented because the IHS only has records for payments actually made. For example, payments by Medicaid are considered payment in full in accordance with Federal regulation. Therefore, when a patient is eligible for Medicaid and Medicaid pays the bill, there are no charges to be paid by the Service or the patient.

The IHS will continue to use the FI to process and pay CHS claims for approximately 50 percent of the CHS budget and recommend its use to tribes. The FI does maximize our ability to process claims and utilize alternate resources.

PERFORMANCE PLAN

The CHS performance indicator is based on the IHS FY 2002 Annual Performance Plan. This indicator represents some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS will be able to accomplish the following:

> Indicator 38: During the FY 2002 reporting period, the IHS will have improved the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements to at least 82 percent at the IHS-wide reporting level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$368,325,000	15	
1998	$373,375,000	2	
1999	$385,801,000	0	
2000	$406,756,000	0	
2001	$445,773,000	0	Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $445,776,000 is an increase of $3,000 over the FY 2001 enacted level of $445,773,000. The increase is as follows:

Built-in Increases: +$3,000

The request of $3,000 will be shared with Title I and Title III tribes, as well as Federal programs to the most extent possible.

It is extremely critical that the IHS maintains the FY 2001 level of service to provide access and continuity of care in primary health. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

HIV/AIDS

INDIAN HEALTH SERVICE	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001
Total Program Level	$3,770,000	$4,078,000	$4,164,000	+$394,000	+$86,000
(FTE).....	(15)	(15)	(15)	0	0

	2000 Actual	2001 Appropriation	2002 Estimate
Risk Assessment & Prevention Surveys			
1. HIV Surveys.....	$985,000	$1,220,000	$1,261,000
Information & Education/Preventive Services			
1. High Risk and Infected Persons			
a. Hlth. Educ./Risk Reduction ..	535,000	535,000	535,000
b. Counseling, Testing & Partner Notification.....	222,000	229,000	239,000
Subtotal.....	757,000	764,000	774,000
2. Special Minority Initiatives....	773,000	794,000	776,000
3. School and College Aged Youth			
a. Program Devel. & Training...	222,000	229,000	239,000
4. General Public & Special Prog.			
a. Regional, State, & Local.....	812,000	841,000	875,000
5. Health Care Workers & Providers			
a. Other Types of Training.....	222,000	229,000	239,000
Subtotal, Info. & Educ./Preventive Services.....	2,785,000	2,858,000	2,903,000
Total.....	$3,770,000	$4,078,000	$4,164,000

PURPOSE AND METHOD OF OPERATION

The Public Health Service (PHS) mission for addressing Acquired Immune Deficiency Syndrome (AIDS) and the Human Immunodeficiency Virus (HIV) epidemic is to prevent further spread of the HIV virus; to provide effective therapies for those already infected; to enhance the capacity of the Nation's public and private organizations at the national, state, and local levels to deliver effective prevention, treatment, and related health care programs to all citizens. To achieve the PHS HIV/AIDS mission, the IHS has implemented programs that include components of risk assessment, education, and prevention to health care workers and American Indian and Alaska Native communities, and treatment of those that have progressed to AIDS and HIV infected persons. Surveys are conducted (questionnaire) that answer questions about what people know about HIV and AIDS.

ACCOMPLISHMENTS

Surveillance

As of June 2000, the IHS has reported 2,234 AIDS cases in AI/ANs.

New HIV infection cases average 120 per year for males. The female HIV infection rate continues to climb and will not stabilize for several more years. Last year there were 33 new female HIV infections. This year there are 50 new HIV infections. The surveys of prenatal, sexually transmitted diseases (STD), and alcohol and drug abuse treatment programs have proved the presence of the virus in virtually all remote Indian communities.

Each IHS Area Office has one full or part-time HIV/AIDS Coordinator that networks with their respective State epidemiologist regarding HIV/AIDS in AI/ANs to enhance surveillance, prevention and treatment efforts. All programs must meet State-reporting requirements. Information is shared with the States and the Centers for Disease Control and Prevention. IHS has one National AIDS Coordinator in Headquarters.

High Risk or Infected Persons

More than 2,000 health care workers in IHS and tribal programs are trained as HIV counselors. This includes substance abuse counselors and mental health program staff.

Risk assessment behavior screening is continuing among women seen in prenatal and other clinics. Similar screening is being done on STD and tuberculosis patients.

With the increased public awareness of the HIV virus, more individuals are seeking counseling and requesting HIV testing. IHS is providing approximately 5,000 voluntary confidential tests annually.

Prevention Services

The IHS AIDS Program is focusing prevention activities in special groups, such as women, tribal leaders, school age youth, community leaders at specific community events such as feasts, pow-wows, schools, health fairs, and rodeos.

Special Emphasis - Urban Prevention Program

The Urban Indian Health programs received a special appropriation of $646,000 in FY 1993 for AIDS education and prevention services. Urban Indian programs now provide testing for high-risk individuals. Some continue to participate in the IHS surveillance.

The programs have developed culturally appropriate HIV Prevention materials, and have identified available resources for care. Initially, the 34 urban Indian programs limited their activities to public awareness campaigns, but are now involved in part-time HIV outreach, intervention, and referral activities for high risked persons.

School and College Age Youth

Limited data suggest that American Indian and Alaska Native youth continue to engage in unprotected sex at an early age. Surrogate data such as teen pregnancy and STD rates support this position. IHS provides AIDS Prevention/Risk Reduction services to all reservation-based schools, school boards, and educators, as well as Teen Clinics, Youth Substance Abuse Treatment Centers, and other youth organizations. Regular training sessions are offered to the Bureau of Indian Affairs school administrators, teachers, and school board members. IHS personnel are participating in school health programs and curriculum development.

Local Programs - Community Awareness

The IHS has provided AIDS Prevention/Risk Reduction services to all AI/AN communities. Nearly all of the IHS service population has heard or seen an AIDS education message. Communities have established local task forces to encourage greater community involvement and to assist lifestyle changes.

Health Care Workers

The local service units maintain continuing medical education programs on HIV prevention for all health care workers. The IHS also provides training on universal precautions and implementation of Center for Disease Control ACTG Protocol 076 to prevent transmission of HIV from infected mothers to uninfected newborn.

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ACTIVITY/MECHANISMS BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
Public and Private Collections

Program Authorization:

Program authorized by Economy Act of 31 U.S.C. 686 Section 301-P.L. 94-437, Title IV of Indian Health Care Improvement Act.

Collections	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	20002 Est. +/- 2001
Medicare	$102,077,000	$107,742,000	$128,790,000	+$26,713,000	+$21,048,000
Tribal Medicare	6,986,000	6,986,000	6,986,000	0	0
Medicaid	261,060,000	293,896,000	302,032,000	+40,972,000	+8,136,000
Tribal Medicaid	22,217 000	22,217,000	22,217,000	0	0
Total	$392,340,000	430,841,000	$460,025,000	+$67,685,000	+$29,184,000
Private Insurance	39,354,000	39,960,000	39,960,000	0	0
Total	$431,694,000	$470,801,000	$499,985,000	+$67,685,000	+$29,184,000
FTE	3,339	3,339	3,339	0	0

Reimbursable Obligation:	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate	Increase or Decrease
Personnel Benefits & Compensation	$191,063,000	$202,048,000	$215,733,000	+$13,685,000
Travel & Trans.	3,458,000	4,181,000	4,398,000	+217,000
Trans. Of Things	941,000	1,217,000	1,258,000	+41,000
Comm./Util./Rents	3,147,000	4,106,000	4,218,000	+112,000
Printing & Repro.	158,000	192,000	199,000	+7,000
Other Contractual Services	62,533,000	78,889,000	81,616,000	+2,227,000
Supplies	50,530,000	64,771,000	67,396,000	+2,625,000
Equipment	5,429,000	6,922,000	7,175,000	+253,000
Land & Structures	893,000	893,000	893,000	0
Grants	113,446,000	107,469,000	116,966,000	+9,497,000
Insur./Indemnities	70,000	82,000	99,000	+7
Interest/Dividends	26,000	34,000	34,000	0
Total	$431,694,000	$470,801,000	$499,985,000	+$29,184,000

PURPOSE AND METHOD OF OPERATION

MEDICARE/MEDICAID

The FY 2001 and FY 2002 Medicare/Medicaid (M/M) estimates reflect the rate increases incorporated in FY 2001. Tribal collections are an estimate because there are no requirements for Tribes operating their own facilities to report this data to IHS. This estimate is based on HCFA data.

The FY 2002 President's Budget assumes that the current 2001 rates will continue into FY 2002. Future IHS rate adjustments and projections will be made based on the results of a complete analysis of current Medicare hospital cost reports.

We project medicare collections to increase in FY 2002 because of the new authority to bill for physician services beginning in July of 2001. We project medicaid collections to increase because of enhance billing systems.

In 2001 and 2002, the IHS will continue to focus on strengthening business office management practices including provider documentation training, procedural coding, processing claims and information systems improvements. In FY 2000, IHS wide efforts were initiated to improve each hospital's capability to identify patients who are eligible or may become eligible for third party reimbursement. A major part of this activity includes the identification of all children who may be eligible for participation in the Children's Health Insurance Program (CHIP). For 2001 and 2002, the IHS will continue working with HCFA and the State Medicaid Offices to help ensure the success of this effort. Other business management practices in progress, including automating Medicare and Medicaid billings and collections will assist IHS in its efforts to increase collections.

The use of the M/M reimbursements will be in accordance with approved JCAHO/HCFA survey plans of correction and with identified maintenance and repair projects. The IHS will continue to place the highest priority on maintaining JCAHO accreditation standards for its health facilities. Specific Service Unit plans will be developed to respond to these projects. These include projects on IHS' backlog of essential maintenance and repair list that effects JCAHO/HCFA standards, including health and safety.

PRIVATE THIRD PARTY COLLECTIONS

In FY 2002, private insurance collections have remained relatively stable due to managed care payment limitations and small numbers of our patients actually having private insurance. During FY 2001 and in FY 2002, IHS will continue its efforts to improve each health facility's capability to identify patients who have private insurance coverage and claims processing to increase private insurance billings and collections. Funds collected will be used by the local Service Units to improve services, including the purchase of medical supplies and equipment, and to improve local service unit's business management practice.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
Preventive Health

Program Authorization: Program authorized by 25 U.S.C. 13, Snyder Act and P.L. 83-568, Transfer Act 42 U.S.C. 2001.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$91,859,000	$95,709,000	$99,724,000	+$7,865,000	+$4,015,000
HIV/AIDS	($535)	($535)	($535)	(0)	($0)
FTE	322	325	333	+11	+8
HIV/AIDS	(1)	(1)	(1)	(0)	(0)

Total Request Level -- The total request of $99,724,000 and 333 FTE is an increase of $4,015,000 and 8 FTE over the FY 2001 enacted level of $95,709,000 and 325 FTE. The explanation of the request is described in the activities that follow.

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Indicator 23: During FY 2002, increase the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) by 1 percent over the FY 2001 level.

Indicator 24: During FY 2002, increase pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 1 percent over the FY 2000 level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$26,676,000	289	
1998	$28,198,000	289	
1999	$30,363,000	284	
2000	$34,452,000	287	
2001	$36,114,000	289	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $37,781,000 and 294 FTE is an increase of $1,667,000 and 5 FTE over the FY 2001 enacted level of $36,114,000 and 289 FTE. The increases include the following:

Built-in Increases: +$1,244,000

The request of $240,000 for inflation/tribal pay cost and $1,004,000 for federal personnel related costs would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

Maintaining the current I/T/U health system by ensuring access and continuity of care is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$423,000 and 5 FTE

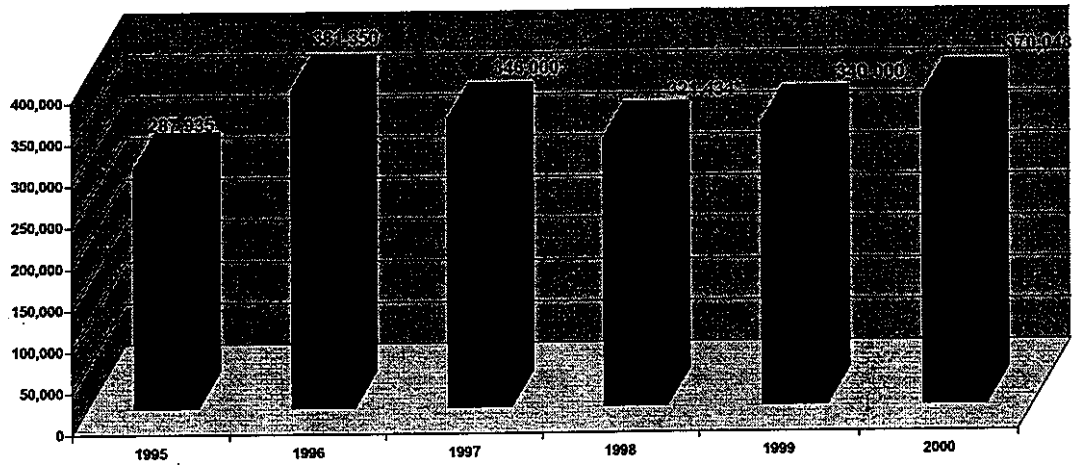
The request of $423,000 and 5 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**
Parker, AZ Health Center	$423,000	5

ACCOMPLISHMENTS

The PHN program has been challenged by vacancies that have not been filled but the PHN program has seen gradual increases in services and a positive clinical outcome of decrease infant mortality rates (see attachment A & B). Also despite these shortages, the PHN program funded four PHN interns, Alpha and Beta tested the PHN PCC form that will generate more specific data, and provided PHN Update Training for Indian countrywide.

PHN Service Data FY's 1995 thru 2000



PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2002 Annual Performance. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to accomplish the following:

Indicator 2: During FY 2002, continue the trend of improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 3: During FY 2002, continue the trend of improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.

Indicator 8: During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 2 percent over the FY 2001 level.

Indicator 22: During FY 2002, increase by 2 percent the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits over the FY 2001 workload levels.

time. Another 20 percent of the PHNs time is spent in activities for children under the age of 5 years. This is a collaborative effort with the Maternal and Child Health (MCH) team.

Because the PHNs are community based their coordination of care includes STDs, AIDs counseling, and education on FAS/FAE. Community assessment and developing population based plans of care are another important PHN activity. Collaboration with State and county agencies to plan appropriate programs to meet the needs of the Indian community often requires input from the I/T/U PHNs.

Findings Influencing FY 2002 Request

PHN services related to preventive care are directly influenced by PHN home visits, including Prenatal care, high immunization rates, post hospitalization home visits for skilled and unskilled nursing care.

The IHS service population is increasing at a rate of about 2 percent per year. The health needs of the growing elder population are increasing at 15 percent of the PHNs home visits. There is increasing priority to address the health disparities that are identified for the AI/NA population.

Public Health Nursing continues to work to eliminate health disparities. American Indians/Alaska Natives have higher rates of cervical cancer. PHNs make home visits to educate at risk women and encourage early screening and follow up to missing appointments.

AI/AN have higher incidence and prevalence of diabetes mellitus and its complications. PHNs conduct home visits to educate the importance of glycemic control to delay the onset of complications based on a plan of care. Hypertension and heart disease are often co-existing conditions with diabetes forcing resources to be channeled into tertiary interventions.

PHNs collaborate with other members of the Maternal and Child Care team to improve health outcome for the mother and child. AI/AN is a young population, greater than 50 percent of its population is in the childbearing years. PHNs make home visits to increase first prenatal visits in the first trimester. Home visits are made to those prenatal patients who have risk factors such as smoking, alcohol and drug use in pregnancy which correlate with poor outcome for the baby. There is documentation that mothers and their children who receive PHN home visits have better outcomes. In F.Y. 2000, 39 percent of the PHNs services were to maternal, child health promotion.

Pockets of AI/AN continue to experience incidences of infectious disease, such as Tuberculosis and Hantavirus, which require stringent investigation of the environment and education on prevention.

Some of the PHN programs have successfully passed accreditation by the National League for Nursing, while many programs have chosen not to continue this accreditation process due to varying funding priorities. In FY 2002, IHS will continue to work with PHN programs on accreditation so that the PHN programs could continue to meet national standards.

PUBLIC HEALTH NURSING

Indian Health Service

Preventive Health	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Public Health Nursing					
Budget Authority	$34,452,000	$36,114,000	$37,781,000	+$3,329,000	+$1,667,000
FTE	287	289	294	+7	+5
Total # of Pt. Visit	340,000	370,048	376,048	+36,048,000	+6,000
Total # of PHN Home Visits Provided	119,000	126,373	128,000	+9,000	+1,627

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

The IHS Public Health Nursing (PHN) is the integration of nursing practice and public health practice applied to the prevention of disease and the promotion and preservation of the health of the Indian population. PHN services are provided to individuals, families, groups, and through these services contribute to the health of the community.

The majority of AI/AN live in rural and isolated communities. Access to modern convenience such as telephone and transportation are not necessarily available to access medical care. Often the PHN is the link to health care in these remote communities. Access to medical care is also a challenge for some AI/AN members who live in urban settings.

PHN is one of the most visible and well-known programs to the Indian tribes because it is entirely community based. Their services are based on the assessed needs of the individuals, families, groups, and communities. The PHN role is one of health education, strengthening relationships with the Indian community and providing the framework for broadly based community efforts, which include: therapy, counseling, education, and coordination of care by referring clients to other disciplines and case management activities. The PHN collaborate with the health care team to deliver the required services.

Best Practices/Industry Benchmark

The PHN program is an integral component in the Indian Health Service/Tribal/Urban (ITU) health programs. The tribes operate approximately one third of the PHN programs. Outreach activities include: home visits, well child examination in remote communities, immunizations, prenatal care and follow up visits for skilled and non skilled nursing care. Home visits continue to be a mainstay of the PHN activities along with case finding which together accounts for over 50 percent of the PHN

HEALTH EDUCATION

Indian Health Service

Preventive Health	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Health Education:					
Budget Authority	$9,625,000	$10,063,000	$10,628,000	+$1,003,000	+$565,000
HIV/AIDS	($535)	($535)	($535)	($0)	($0)
FTE	35	36	39	+4	+3
(HIV/AIDS FTE)	(1)	(1)	(1)	(0)	(0)
Total Hlth. Educ. Services Provided	600,000	600,0000	600,000	0	0

PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

The IHS Health Education Program is committed to a partnership with American Indian and Alaska Native (AI/AN) communities to raise the health status of AI/AN to the highest possible level. This is accomplished through education, leadership and promoting community capacity building that nurtures healthy lifestyles and utilization of health services. In addition, the Health Education Program fosters participation of AI/AN communities in developing and managing programs to meet their health priorities.

The emphasis of the IHS Health Education is to strategically improve and strengthen the practice of public health education, to take an active role in community health planning as determined by sound epidemiological data. The IHS Health Education adheres to proven intervention strategies that are driven by community-based priorities identified by local communities. The Health Education Program has identified these priorities that encompass the core practices of public health education - community health, school health, employee health promotion, and patient education:

- To provide leadership in developing safe and healthy Indian communities.
- To develop and strengthen a standardized, nationwide patient education program.
- To enhance the capacity of those schools that educate Native Americans and Alaskan Natives to respond to threats to youth health.
- To assist Head Start programs in the provision of health education activities.
- To support the IHS Director's youth, elderly and women's priorities.
- To support diabetes education.

- To accomplish these activities, partnerships have been developed with health programs, tribes, schools, communities, educational institutions, public and private foundations. The IHS Health Education program will assist our partners to engage in community-based prevention activities, such as smoking cessation, diabetes education, HIV/AIDS/STD risk behavior education, injury prevention, obesity and physical inactivity, and hearing loss.

The Health Education Program has been active through the development and completion of a Web site that includes Health Education recruitment information, the IHS Patient Education Protocols/Codes, and a directory of all I/T/U health education programs. In addition, the Program has designed and implemented a new aspect to the Health Education Resource Management System (HERMS) that automatically translates raw monthly HERMS data into more user friendly forms, such as charts, graphs, etc.

Based on preliminary analyses of FY 2000 health education workload data, approximately 40 percent of the eligible AI/AN population had access to health education services.

Best Practices/Industry Benchmarks

The IHS Health Education Program has a long history of serving as a benchmark and Federal model of health education services. It is one of the few health education programs nationally that serves such diverse health education needs working with over 561 tribal entities. Most recently, the program has embarked on a model "Patient Education Project" that allows outcome measurements to be obtained for health education services to meet the new JCAHO standards for health/patient education. New FY 2001 ORYX Indicators have also been developed to track health education in our hospitals, clinics and community programs on breast self-exams, diabetes and exercise, smoking cessation, and breast-feeding.

ACCOMPLISHMENTS

- The National Patient Education Project has been successfully implemented in approximately 30 of the more than 80 IHS hospitals and clinics. The objective of this project is to standardize patient education for I/T/Us. The ultimate goal is to institutionalize this in all areas over the next two years.

- The IHS Health Education Web Site has been completed.

- ORYX indicators will be used to evaluate health education and patient education efforts in medications, smoking cessation, breast self-exam, breast-feeding, diabetes and exercise. FY 2000 ORYX Statistics indicated that the total number of Patient and Family Education (PFE) activities was 472,819.

- The updating and revision of the Health Education Resource Data Management System (HERMS) has been completed and is being marketed nation-wide. All health education programs are welcome to use the system, which is free of charge and is located on the IHS Health Education Web Site.

- Update of the Health Education chapter in the IHS Manual has been completed and awaits approval. The chapter has been revised to reflect the Tribal compacting and contracting activities.

- The IHS Health Education program has joined a national collaborative initiative with the National Institutes of Health to reduce noise-induced hearing loss and otitis media.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At this funding level, IHS will be able to achieve the following in FY 2002:

Indicator 2: During FY 2002, continue the trend of improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 3: During FY 2002, continue the trend of improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.

Indicator 6: During FY 2002, increase the proportion of women 18 and older that has had a Pap screen in the previous year by 2 percent over the FY 2001 level.

Indicator 7: During FY 2002, increase the proportion of the AI/AN female population over 40 years of age that has received screening mammography in the previous two years by 2 percent over the FY 2001 level.

Indicator 28: During FY 2002, the IHS will continue collaboration with NIH to assist three AI/AN communities to implement culturally sensitive community-directed pilot cardiovascular disease prevention programs.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$8,632,000	45	
1998	$8,932,000	43	
1999	$9,430,000	37	
2000	$9,625,000	35	
2001	$10,063,000	36	Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $10,628,000 and 39 FTE is an increase $565,000 and 3 FTE over the FY 2001 enacted level of $10,063,000 and 36 FTE. The increase includes the following:

Built-in Increases: +$303,000

The request of $167,000 for inflation/tribal pay cost and $136,000 for federal personnel related costs would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

Maintaining the current I/T/U health system by ensuring access and continuity of care is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$262,000 and 3 FTE

The request of $262,000 and 3 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities.

The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**
Parker, AZ Health Center	$262,000	3

COMMUNITY HEALTH REPRESENTATIVES (CHR)

Indian Health Service

Preventive Health	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Community Health Representatives:					
Budget Authority	$46,380,000	$48,061,000	$49,789,000	+$3,409,000	+$1,728,000
Number of CHRs	1,612	1,612	1,612	0	0
# of Tribally Operated Svcs Provided	2,200,000	2,200,000	2,200,000	0	0

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

As tribally contracted and compacted programs, the 215 Community Health Representative (CHR) programs are tribally administered outreach programs. They are based on the concept that American Indian/Alaska Native (AI/AN) community members, trained in the basic skills of health care provision, disease control, and prevention, can successfully create change in community acceptance and utilization of Western health care resources. The Indian Health Service works with tribes and provides leadership and guidance to the CHR program.

The CHR Program plays an important role in the successful implementation of IHS/Tribal health promotion/disease prevention initiatives and efforts to improve access to medical services. CHRs are indigenous people well positioned within their communities to provide the needed educational and related services that can result in healthier lifestyles and early treatment and lower morbidity among their people. The CHRs are proven effective outreach health care providers and have established an efficient network system through which health promotion/disease prevention and health care access are being delivered to the AI/AN people.

ACCOMPLISHMENTS

The Community Health Representative program has developed two reporting methods to record the services provided by CHRs: the RPMS/PCC Direct and the RPMS/PCC Remote Reporting. The IHS encourages tribes to report data such as the number of client-patient contacts and the number of service hours spent on health education, case management, patient care, case finding, monitoring, and transporting patients in the health areas of diabetes, hypertension, health promotion/disease prevention, alcohol/substance abuse, cancer, communicable diseases. However at this time, complete data is not available.

The Community Health Representative Program launched a new CHR Web Site providing access to a CHR Newsletter. Future capabilities will permit us to download local and regional reports from the RPMS/PCC Direct and the

RPMS/PCC Remote Reporting as well as other general information about the CHR program.

In consultation with the Tribal CHR program, a major focus is on training. The CHR Program provides 3-Week CHR Basic training sessions to assist Community Health Representatives to obtain health and medical education appropriate to the CHR program. The CHR program also provides CHR Refresher training sessions for those CHR staff that have been employed by the local CHR program for more than two-years.

The CHR Program also revised the curriculum for the 3-Week Basic training manual as well as the CHR Refresher training manual. The manuals were distributed to all 215 CHR tribal programs.

The Community Health Representative Program has joined partnership with the Environmental Protection Agency to develop culturally appropriate training materials for use in educating Native American and Alaska Natives on the subject of Indoor Air Quality.

The Community Health Representative Program continues to maintain a close working relationship with the National Association of Community Health Representatives joining forces to elevate the health status of Native Americans and Alaskan Natives to the highest possible.

PERFORMANCE PLAN

The performance indicators are included in the IHS FY 2002 Annual Performance. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to accomplish the following:

Indicator 2: During FY 2002, continue the trend of improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 8: During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 2 percent over the FY 2001 level.

Indicator 23: During FY 2002, increase the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) by 1 percent over the FY 2001 level.

Indicator 24: During FY 2002, increase pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 1 percent over the FY 2000 level.

Following are the funding levels for the last 5 fiscal years:

1997	$44,973,000	12	
1998	$44,312,000	13	
1999	$45,960,000	5	
2000	$46,380,000	0	
2001	$48,061,000	0	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $49,789,000 is an increase of $1,728,000 over the FY 2001 enacted level of $48,061,000. The increase includes the following:

Built-in Increases: +$1,728,000

The request of $1,728,000 for inflation/tribal pay cost would partially fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

Maintaining the current I/T/U health system by ensuring access and continuity of care is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

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HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

Indian Health Service

Preventive Health	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Hepatitis & Haemophilus Influenza Immunization Program (Alaska)					
Budget Authority	$1,402,000	$1,471,000	$1,526,000	+$124,000	+$55,000
Services Provided					
IHS Operated:					
* # hepatitis patients given clinical care.	2,500	2,900	2,900	+400	0
# chronic carriers surveyed.....	1,482	1,492	1,492	+10	0
** # patients immunized: Hepatitis A/B.	6,900	8,400	8,400	+1,500	0
# Hepatitis C patients followed.....	650	800	900	+250	+12.5 percent
•Evaluate long-term protection of Hep. A vaccine.....	150	400	400	+250	0
•Evaluate need for hepatitis B booster doses:					
Infants/Children.	1,482	1,982	1,982	+500	0
Adults.....	2,800	3,000	3,000	+200	0
Immunization Records Audited:...	2,000	3,000	3,000	+1,000	0
# Trained in RPMS software:.....	65	75	90	+25	+20 percent
***Purchases of vaccine (adult):					$0
Hepatitis A...	$50,000	$50,000	$50,000	$0	$0
Hepatitis B...	$50,000	$50,000	$50,000	$0	

*These patients have diagnostic exams and procedures performed by hepatitis program staff at rural field clinics and at Alaska Native Medical Center.

**These figures represent patients immunized in hepatitis A/B studies, and adult vaccination with program-purchased vaccine. Changes in figures represent hepatitis A vaccination of adults with chronic hepatitis C infection.

Individual Native tribal corporations and State Public Health Nurses provide Childhood vaccines, including Hib vaccine.

***These figures represent the purchase of adult Hepatitis A and B vaccines agreed upon in the Alaska compacting tribes funding agreement with IHS. Hepatitis B vaccine is offered to any susceptible Alaska Native adult. Hepatitis A vaccine is offered to non-immune adults in high-risk groups.

PURPOSE AND METHOD OF OPERATION

The Viral Hepatitis Program (Hepatitis B Program) and the Immunization (Hib) Program are distinct programs of the Alaska Native Tribal Health Consortium (ANTHC).

Tribal Contracts:

Bristol Bay Health Corp.	133,000
Yukon Kuskokwim Health Corp.	228,500
Total	361,500

Tribal Shares: The 2001 budget is 100 percent tribal-administered in the Alaska Tribal Health Compact, and an agreement by Annual Funding Agreement to support the activities and personnel described below:

Hib Immunization	295,000
Hepatitis	840,400
Total	1,135,400
TOTAL Tribal Contracts and Shares	1,496,900

Viral Hepatitis Program

The objective of the Viral Hepatitis Program is to deliver comprehensive hepatitis A, B and C control services to Alaska Natives. The Hepatitis B Program began in 1982 to stop the spread of hepatitis B in Alaska Natives by mass immunization, and to prevent premature death in chronically infected persons by early liver cancer detection. Since 1990 the Program has expanded to include control of hepatitis A infection, detection and control of hepatitis C infection, and identification and research into non-A, B, C, hepatitis infection.

Current activities of the Viral Hepatitis Program include:

- provision of hepatitis B vaccine for susceptible Alaska Native adults, and new Alaska IHS employees,
- continuation of four long-term immunogenicity and efficacy studies to determine when booster hepatitis B vaccine doses are planned,
- surveillance of 1,500 chronic hepatitis B carriers twice yearly for early liver cancer detection (detecting 34 patients with hepatocellular cancer), and for the development of potentially treatable chronic hepatitis.
- studies on the long-term immunogenicity of hepatitis A vaccine in infants and children and adults,
- Hepatitis A vaccination of high risks Alaska Native adults including those with chronic liver disease and injectable drug users.
- provision of hepatitis A vaccine to 2 to 18 year old children using vaccine provided by the State of Alaska,
- development and administration of a Statewide system of surveillance that assures appropriate care of persons chronically infected with hepatitis C,
- development of anti-viral strategies for hepatitis C infections, including initiating study on 500 adults chronically infected with hepatitis C to determine the clinical course and develop preventive and treatment strategies including the use of anti-viral medications,
- collaboration with other agencies to identify additional hepatitis viruses and develop prevention and treatment strategies,
- provision of hepatitis field clinics in rural areas, and education to health providers and patients,
- studies using new antiviral drugs to treat hepatitis C, and
- Implementation of 3 model "look back" programs to screen persons at high risk for exposure to hepatitis C who had a history of receiving blood products or have used injectable drugs in the past. Program will involve up to 4,000 Alaska Natives.

Hib Immunization Program

The objective of the Haemophilus influenza Type B (Hib) Immunization Program is to provide resources, advocacy, training, immunization tracking and coordination of immunization delivery services among Alaska Native tribal programs in order to achieve and maintain high levels of on-time immunization, required to eliminate Hib and other vaccine-preventable diseases in Alaska Natives. Before the advent of Hib vaccines in the late 1980s, Alaska Natives had record rates of Hib meningitis, 6 - 10 times those of other U.S. populations, with a preponderance of disease in young infants. The Program was implemented to prevent Hib disease in Alaska Native infants with on-time immunization. In 1992 the Program objective was expanded include achieving high on-time immunization levels for all recommended childhood vaccines, at 2, 4, 6, 12, and 24 months of age. With the decrease in Hib disease, pneumococcus has emerged as the most common cause of meningitis and blood infections in Alaska Native infants and children who have a rate of pneumococcal disease 4 times that in non-Alaska

Natives. In January 2001, pneumococcal conjugate vaccine was added to the infant vaccine schedule. The Program has educated providers, developed training materials, developed a promotional poster, and updated immunization software to encourage the use of pneumococcal conjugate vaccine.

The current strategies utilized by the Program are:

Assessment. Regular immunization audits with tribal contractors to monitor progress toward achieving immunization goals and identify problems in vaccine delivery. Development of computerized immunization records in each tribal program, to improve recall of patients and assessment of immunization rates.

Training and Feedback. Annual training for regional immunization coordinators; periodic vaccine updates to clinical directors, pharmacists, and health providers; regular training of Community Health Aides and development and distribution of vaccine training materials. Training, promotion and consultation for implementation of universal vaccination with the new pneumococcal conjugate vaccine.

Computerized Immunization. Registry/GCPR - principal consultants and trainers IHS-wide for the computerized IHS immunization software package, released IHS-wide in December 1999. Consultant on software revision Version 7.1. IHS immunization consultant for the Government Computerized Patient Record (GCPR) project.

Advocacy/Coordination with the State. There are regular meetings with the State of Alaska Immunization Program to promote vaccine policies that optimize disease prevention in Alaska Natives, and to achieve a unified immunization schedule for the State.

Vaccine Promotion. - Development of vaccine promotional materials and coordination of regional and statewide efforts to promote timely vaccination, of children and increase adult vaccination. We received a CATCH planning grant from AAP to develop infrastructure to improve immunization rates in rural Alaska.

Vaccine Purchase. Purchase of vaccines not supplied by the State of Alaska Immunization Program (e.g., MMR for 2nd dose in 1992-1996, Influenza to cover shortfall of State vaccine), and PedvaxHIB in 1996-7 to replace the State-provided vaccine shown to be less effective in young Alaska Native infants).

Respiratory syncytial virus (RSV) Prophylaxis Project. Surveillance of RSV hospitalization through Arctic Investigations Program - Centers for Disease Control (AIP-CDC); a study at AIP-CDC to evaluate the impact of using RSV monoclonal antibody to prevent RSV hospitalizations in high-risk infants; and a cohort study through AIP-CDC and collaborators to evaluate the effect of early RSV hospitalization on development of chronic lung disease and asthma in childhood.

Disease Surveillance and Analysis. - Analysis of AIP-CDC surveillance data on pneumococcus and Hib enabling us to detect and respond to changes in disease patterns; collaboration with AIP-CDC to monitor the impact of infant vaccination on disease and nasopharyngeal carriage; proposal to

study the impact of pneumococcal vaccine in preventing disease in elders and promote pneumococcal vaccination of adults.

The Viral Hepatitis Program has been recognized as the national and international leader in the prevention and control of viral hepatitis, and communicable disease experts worldwide are monitoring its performance.

ACCOMPLISHMENTS

Since its beginnings, in 1982, the Viral Hepatitis Program has reached all the high-risk villages in Alaska and has the potential for eradicating hepatitis B. By 1988 the majority of Alaska Natives were immunized against hepatitis B, if not previously infected. More than 96 percent of Alaska Native newborns receive a dose of hepatitis B vaccine before hospital discharge. The annual incidence of acute symptomatic hepatitis B infection has decreased from 215 per 100,000 prior to 1982, to 5 per 100,000. The 1-year case-fatality rate for primary liver cancer has decreased from 100 percent to 50 percent. In FY 2002 liver function tests will be added to the semiannual screening test for liver cancer (AFP) to identify patients with severe asymptomatic hepatitis who could be candidates for newly licensed antiviral medications to prevent end stage liver disease and need for subsequent liver transplantation.

Since 1989 the Program has conducted studies on the immunogenicity, safety and efficacy of hepatitis A vaccine in infants and adults. In 1993 the program, in collaboration with the State of Alaska and four regional Native health corporations, conducted a project that demonstrated that one dose of hepatitis A vaccine could halt a large outbreak of hepatitis A. The Program is now conducting studies of the effectiveness of hepatitis A vaccine in infants. Other recent accomplishments include initiation of studies on hepatitis B boosting and long-term immunogenicity of hepatitis A vaccines, and the development of a cancer detection program for persons chronically infected with hepatitis C. The latter has involved development of a registry of persons with hepatitis C, currently approaching 1000 Alaska Natives, and the development and implementation of a plan to screen Alaska Natives at high risk for hepatitis C (persons who received blood transfusions or had cardiac surgery prior to 1992). In addition, in FY 2001 the program will begin to contact all Hepatitis C infected persons twice yearly for AFP testing to detect liver cancer early and liver function tests to identify potential treatment candidates.

Hib Immunization Program

The Hib Immunization program conducts or reviews audits in 12 Alaska Native regions, which have documented an increase in 2-year old immunization rates in Alaska Natives from 49-73 percent in 1990, to 76-98 percent in 1998-9, with more than 90 percent fully, immunized against Hib disease.

Through expanded immunization tracking in Anchorage the 2-year old immunization rate in Anchorage Alaska Natives increased from 81 percent in 1996 to 94 percent in 2000, while the age-appropriate immunization rate in

3-27 month olds increased from 76 percent to 85-89 percent. The Program continues to provide clinical development, testing and training of the new IHS Immunization software package for the computerized Registration and Patient Management System (RPMS). This package, which provides expanded opportunities for immunization tracking and recall, was completed and released IHS-wide in December 1999and revised in 2000.

The Program has successfully collaborated with the State in a immunization initiative resulting in a state-wide increase in 2-year-old immunization rates according to the National Immunization Survey from 69 percent in 1996 to 81 percent in 1998 (the Alaska Native immunization rate was 87 percent in 1998). The Program assisted with a finalized American Academy of Pediatrics (AAP) statement on Immunizations for American Indians and Alaska Natives.

An emphasis on adult immunizations has resulted in influenza vaccination of >60 percent and pneumococcal vaccination of >80 of elders in at least 1 region (Fall 1999).

The Program collaborated with AIP-CDC in studies that justified to the State of Alaska the need for the use of the Hib vaccine, PedvaxHib®, for the first dose. Since instituting this schedule the number of Hib infections has decreased with most cases occurring in under-immunized infants.

In 2000, we completed the first phase of a study to evaluate the effect of early RSV hospitalization on development of childhood lung disease and asthma. Preliminary data shows that children hospitalized with RSV are at higher risk for wheezing illnesses and lower respiratory illnesses until at least 4 years of age. This year's activities include further data collection; report the health board, and development of interventions.

FY 2001 IHS ESTIMATED EXPENDITURE FOR IMMUNIZATIONS

The following method was used to estimate FY 2001 expenditures for immunization services in the IHS. Since the IHS patient care data system is not structured to measure itemized costs for the treatment of various conditions, an indirect method was used to compute this estimate.

Immunization costs were categorized into three target populations. These include infants and children (3 to 27 months of age), adults (greater than or equal to 65 years of age), and the Alaska Immunization project target population. Estimates were calculated for each group as follows:

1. Infants and children: The target population for 2000 was estimated from existing IHS demographic projections as 78,578. An immunization rate for this group is about 88 percent. The cost of vaccine is borne by the Vaccines for Children (VFC) Program. The cost to administer all immunizations over the full series (6 clinic visits at $25 per visit) is $150. The estimated cost for this population segment therefore is $10,372,296.

2. Adults: To estimate the expenditures for adult immunizations, an estimate of the 2000 user population greater than or equal to 65 years of age was used (86,993 persons). Several IHS studies have measured immunization rates for adults at risk at between 30 and 70

percent. The median of 50 percent coverage was used in this estimate, as well as a projected cost for meeting HHS HP 2010 goals of 90 percent coverage. The cost of medication and cost for administration for adult immunization was estimated at $33 ($8 for flu and pneumovax vaccine and $25 for cost of administration). The estimated cost for immunizing this population is estimated to be $1,435,384.

3. Alaska Immunization program: The FY 2001 appropriation for the Alaska immunization program is $1,471,000.

By combining these three groups an estimate of $13,278,680 is calculated for IHS immunization expenditures in FY 2001.

This amount is likely an under estimate for several reasons: 1) Individuals outside these target groups are regular recipients of immunizations (e.g. HBg immunization for health care workers and those at specific risk for other immunizable diseases), however, there is not a good way to estimate the size of these groups; 2) no measure is available for the cost of monitoring (e.g., immunization registries); and 3) no attempt was made to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program.

PERFORMANCE PLAN

The following performance indicators are included in the National IHS FY 2002 Annual Performance Plan. At this funding level, IHS will be able to accomplish the following:

Indicator 23: During FY 2002, increase the proportion of AI/AN children ho have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) by 1 percent over the FY 2001 level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$1,328,000	0	
1998	$1,328,000	0	
1999	$1,367,000	0	
2000	$1,402,000	0	
2001	$1,471,000	0	Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $1,526,000 is an increase of $55,000 over the FY 2001 enacted level of $1,471,000. The increase includes the following:

Built-in Increases: +$55,000

The request of $53,000 for inflation/tribal pay cost and $2,000 for federal personnel related costs would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases.

Maintaining the current I/T/U health system to ensure access and continuity of care is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
URBAN HEALTH PROGRAMS

Program Authorization:

Program authorized by Title V, P.L. 94-437, Indian Health Care Improvement Act, as amended.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority, Less Project..	$27,813,000	$28,843,000	$29,947,000	+$2,134,000	+$1,104,000
Total FY 2001 One-Time Project (SIPI)	0	1,000,000	0	0	-1,000,000
Total Budget Authority.....	$27,813,000	$29,843,000	$29,947,000	+$2,134,000	+$104,000
(HIV/AIDS	($773,000)	($820,000)	($851,000)	(+$78,000)	(+$31,000)
FTE.....	5	5	5	0	0
Program Output Data:					
Services Provided:					
Medical.....	263,000	265,000	265,000	+2,000	0
Dental.....	54,000	69,000	54,000	0	-15,000
Outreach/Comm Services...	219,000	221,000	221,000	+2,000	0
Other.....	185,000	186,000	186,000	+1,000	0
Total.....	721,000	741,000	726,000	+5,000	-15,000

PURPOSE AND METHOD OF OPERATION

The 1990 census indicated that 739,108 or 37.7 percent of the total U.S. Indian population lived in Indian areas, and that 1,220,126 or 62.3 percent lived in non-Indian areas. Indian areas include reservations, off-reservation trust lands, Alaska Native Regional Corporations, Alaska Native Village statistical areas.

It should be noted that about 36 percent of the IHS service area population resides in non-Indian areas, since the IHS service area includes the "on or near" reservation counties that comprise the contract health service delivery areas.

The IHS Urban Indian Health Program supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care Improvement Act. Approximately 332,000 American Indians use Title V Urban Indian health programs and are not able to access hospitals, health clinics, or contract health services administered by the IHS and tribal health programs because they either do not meet IHS eligibility criteria

or reside outside of IHS and tribal service areas. The projected $104,000 will not allow the program fully offset inflation costs and therefore patient care services will not increase.

Studies on the urban AI/AN population documented poor health and revealed limited health care options for most families. Since 1972, the IHS has gradually increased its support for health related activities in off-reservation settings aimed at assisting AI/AN populations to gain access to available health services, and also to develop direct health services when necessary.

In the 1992 amendments to the Indian Health Care Improvement Act, the Congress specifically declared the policy of the Nation "in fulfillment of its special responsibilities and legal obligations to the American Indian people to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy." The IHS addresses this responsibility by funding 34 urban Indian health organizations operating at 41 sites located in cities throughout the United States. Primary care clinics and outreach programs provide culturally acceptable, accessible, affordable, accountable, and available health services to an underserved urban off-reservation population.

The 34 programs engage in a variety of activities, ranging from the provision of outreach and referral services to the delivery of comprehensive ambulatory health care. Services currently include medical services, dental services, community services, alcohol and drug abuse prevention, education and treatment, AIDS and sexually transmitted disease education and prevention services, mental health services, nutrition education and counseling services, pharmacy services, health education, optometry services, social services, and home health care. Fourteen of the programs are designated as Federally Qualified Health Centers (FQHC) and provide services to Indians and non-Indians.

Ambulatory medical care services are provided throughout the off-reservation Indian health programs, including: pre-and postnatal care; women's health; immunizations for both children and adults; pediatrics; chronic disease (geriatric health and diabetes) clinics; adult health; maintenance; acute medical care, infectious disease treatment and control (tuberculosis, sexually transmitted disease); and referral to specialized providers when needed.

Dental care services are provided by many programs, including direct patient care - preventive and restorative. Dental education and screening for both children and adults are provided in both the clinic and community settings. When needed, referrals are made to specialists for orthodontics, periodontics, selected restorative procedures, and oral surgery.

Community outreach services are provided throughout the urban (off-reservation) health programs, including: patient and community education; patient advocacy; outreach and referral; and transportation. The outreach worker serves an important function as a liaison between the off-reservation health program and the community, and works to make health services more available and accessible to those community members who need them.

Alcohol and substance abuse prevention, education, treatment, and rehabilitation services are provided through program and community based services. Included as prevention and education programs are as follows: community education conferences, seminars, and workshops targeting adolescents; identification of high-risk clients in the clinic and community; and appropriate referral for those at risk. Included in the treatment and rehabilitation programs are assessments for alcohol and drug abuse, appropriate intervention, outpatient and treatment programs, and aftercare and follow-up services.

Alcohol treatment services are provided at 10 off-reservation Indian sites originally funded by the National Institute of Alcohol Abuse and Alcoholism (NIAAA). Funds were transferred into the Urban Indian Health Program in FY 1993 to continue these Urban treatment centers under Title V of the Indian Health Care Improvement Act. The NIAAA programs, established within urban sites, are in the final stages of being transferred.

The AIDS and sexually transmitted disease (STD) information is provided at conferences, seminars, workshops, and community meetings at all of the IHS Title V funded off-reservation Indian health programs. These education and prevention services include culturally sensitive information provided to a variety of audiences through the use of posters, pamphlets, presentations, and community education. Additional AIDS services include HIV testing, pre and post-test counseling, family support groups, and referral for additional treatment if needed.

Mental health and social services include individual family and group counseling and support groups to address the problems of abuse, self-esteem, depression, and other emotional problems and conditions. Additional services available at various off-reservation Indian health programs include, primary and secondary prevention activities, i.e., diabetes, maternal and child health, women's health, men's health, nutrition education, counseling for prenatal care, chronic health conditions, social services, community health nursing, home health care, and other health promotion and disease prevention activities.

ACCOMPLISHMENTS

Some of the accomplishments of the urban Indian health program (UIHP) include: continued substantial programmatic involvement with the national urban Indian health organization through a cooperative agreement, continued participation in the IHS budget formulation process, participation in the reauthorization of the Indian Health Care Improvement Act (P.L. 94-437), facilitation of urban Indian health program board of director training, and planning for urban information technology and data collection.

The national urban Indian organization is the National Council of Urban Indian Health (NCUIH). The Council focuses on its' policy concerns and communications among the nation's urban Indian health programs.

The urban Indian health program was involved in and participated in the FY 2000 and FY 2001 budget formulation processes. The purpose is to formulate a budget that reflects the priorities of the Indian Health Service, Tribal health programs and urban Indian health programs.

The urban Indian health program provided board of director training to urban Indian health programs throughout the nation. The training addresses the roles and responsibilities of a board of directors, as well as its relationship to its executive directors. An outcome of the training is the development of a specific plan of action for each participating board of directors.

The urban Indian health program is continuing to refine its present stand-alone data collection system known as the Urban Common Reporting Requirements (UCRR). The Urban Indian Health program is supporting the continuing implementation of a project for improved processes that provide data to the IHS Data Center.

Performance Plan

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At this funding level, IHS would be able to achieve the following:

Indicator 16: By the end of FY 2001, at least 30 percent of the Urban Indian health care programs will have implemented mutually compatible automated information systems that capture health status and patient care data.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$24,768,000	9	
1998	$25,288,000	5	
1999	$26,382,000	4	
2000	$27,813,000	5	
2001	$29,843,000	5	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $29,947,000 and 5 FTE is an increase of $104,000 over the FY 2001 enacted level of $29,843,000 and 5 FTE. The increase includes the following:

Built-in Increases - +$1,104,000

The request of $1,084,000 for inflation/tribal pay cost and $20,000 for Federal personnel related cost would fund the built-in increases associated with on-going operations. Included are the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service for American Indians and Alaska Natives. The IHS patient population is disproportionately affected by chronic diseases such as diabetes and requires more access to health care than the general U.S. population. A continued support of current services is essential to ensure continuity of care.

Non-recurring Funds - -$1,000,000

The FY 2002 Budget includes a reduction of $1,000,000 for a non-recurring dental services activity.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
INDIAN HEALTH PROFESSIONS

Program Authorization:

Public Law (P.L.) 94-437, the Indian Health Care Improvement Act (IHCIA), as amended, authorizes program, Title I, Indian Health Manpower.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$30,491,000	$30,486,000	$30,565,000	+$74,000	+$79,000
FTE	20	20	20	0	0

PURPOSE AND METHOD OF OPERATION

The Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, as amended, cites as national policy the elevation of the health status of American Indians and Alaska Natives (AI/AN) to the highest possible level. Critical elements of this policy are Title I, Indian Health Professions, and Title II, Health Services. These titles support three interdependent objectives: (1) enable AI/AN to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; (2) serve as a catalyst to the development of Indian communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and (3) help to ensure the continued staffing of Indian health programs with well qualified health care providers.

The IHS has implemented sections 102, 103, 104, 105, 108, 110, 112, 114, 120, and 217 of the IHCIA as funds have been appropriated. These sections of Title I, coupled with Section 217 (Title II), of the IHCIA provide authorizations to support a scholarship program, a loan repayment program, temporary employment of students during nonacademic periods, tribal recruitment and retention and matching scholarship programs, health professions recruitment programs, and programs to develop and maintain American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field.

Scholarships help to create health professionals

The scholarship and loan repayment programs each play a role in the recruitment and retention of health professionals but from different perspectives. Scholarships are recruitment tools in three ways:

1. They affect the "creation" of a health professional by

   a. Supporting recipients as they prepare for entry into a health professional school, through section 103; and

b. While they are actually pursuing a health professional education (section 104).

2. They enable students who could never have afforded to finance an advanced education on their own to become health professionals; and

3. They require section 104 recipients to incur a service obligation. This obligation must be satisfied by providing services in an Indian health program in the profession for which the person was trained.

Scholarships become retention tools after the recipient has served their obligation because the person has been exposed to life in Indian health and is likely to decide to remain. In many instances, scholarship recipients serve their obligations in facilities on or near their home reservations and are inclined to remain there.

Loan Repayment attracts already-trained professionals.

The loan repayment program works from the other end of the educational continuum. When a person applies for loan repayment, they have completed, or nearly completed, their training and are ready to begin working in their chosen profession. Most health professionals have incurred substantial debt loads over the time of their education (The average debt load of the 272 people entering the loan repayment program in FY 2000 was $64,000.), so the opportunity to pay them off while working in their chosen profession is very attractive. Because it is possible to renew their contracts until their loans are paid off, the program is also an excellent retention tool.

These programs, as well as other recruitment and retention incentives, are necessary because Indian health programs are experiencing critical shortages of physicians, nurses, dentists, pharmacists, and optometrists and a growing concern in other professions essential to staffing Indian health programs, e.g., laboratorians, medical imaging personnel, mid-level providers, mental health professionals, etc. The Indian Health Professions recruitment and retention activities authorized in sections 102 and 110 are essential to enabling Indian health programs to effectively staff and manage their comprehensive health care delivery system. Competition for health care professionals will continue to increase in FY 2002, with vacancy rates and turnover rates also expected to increase. This will place an ever-greater burden on the IHS Indian Health Professions recruitment and retention programs.

In FY 2000, the IHS made 26 grants to tribes, Indian organizations, and academic institutions to assist in the recruitment, retention, and education of health professionals

Section 102 authorizes grants to public or nonprofit private health or educational entities, Indian tribes, or tribal organizations to identify AI/AN interested in the health professions and recruit them into the health professions. The grantees provide nurturing and cultural support for AI/AN students as they move from reservation settings to the world of academia. In FY 1999, awards were made to the Lac Courte Oreilles Tribe, the Chippewa Cree Tribe, and the Northwest Portland Area Indian Health Board. These grants are for a project period ending July 31, 2002.

During FY 2000, the programs funded under the authority of Section 102 provided career information and counseling to more than 1,500 AI/AN students. These

programs also provided scholarship and career information to more than 80 percent of their new applicants for other programs in public health as well as expanding their recruitment roles to include all health professions. The students recruited by these consortia and tribes are AI/AN individuals who have expressed interest in returning to their Indian communities to practice their health profession.

Section 103 authorizes two scholarship programs, the Health Professions Preparatory Compensatory Preprofessional Scholarship and the Health Professions Preparatory Pregraduate Scholarship. The Health Professions Preparatory Compensatory Preprofessional Scholarship provides funding to AI/AN students for up to 2 years for preprofessional education leading to enrollment in a health professions curriculum and support for compensatory education required for acceptance into a health professions curriculum. In FY 2000, 37 new scholarships were awarded in this section, with 46 extensions.

The Health Professions Preparatory Pregraduate scholarship program authorized under Section 103 provides funding for up to 4 years to AI/AN students who are in premedicine or predentistry. For FY 2000, there were 45 new awards in this section and 61 extensions.

Section 104 authorizes scholarships to AI/AN students who are enrolled or accepted for matriculation in the health professions leading to graduation and service in the IHS and other Indian Health Programs. Upon graduation in the health professions curriculum, these students are obligated to serve for from two to four years, providing professional services to AI/AN people by working in the IHS, tribal health programs funded under P.L. 93-638 (the Indian Self Determination Act), Urban programs funded under Title V of P.L. 94-437, or in private practice in a health professions shortage area serving a substantial number of Indians as determined by the Secretary, DHHS. FY 2000 saw 60 new awards and 287 extensions in this section.

Section 105 authorizes the IHS Extern Program. This program provides Health Professions Scholarship recipients and other health and allied health profession students the opportunity to gain practical experience during non-academic periods of the school year by working in the IHS. The Extern Program provides for one round trip to the work site from school and provides the funding for the individual's salary while they are in the externship. All Section 104 scholarship recipients are entitled to an externship during any non-academic period of the year. Other students are eligible to participate in the Extern program during any non-academic period provided funds are available after the Health Professions students are funded. In a fiscal year, approximately 240 externs have participated in the program.

Section 108 authorizes the repayment of loans incurred by health professionals during their education in exchange for a minimum service obligation of 2 years in the IHS, tribal programs funded under P.L. 93-638 or Buy Indian contractors funded pursuant to 25 U.S.C. 47, or Title V (P.L. 94-437) urban Indian programs. In FY 2000, 334 contracts were awarded to participants in the IHS Loan Repayment Program. Of those, 62 were renewals.

Section 110 authorizes the IHS to fund competitively Indian tribes and tribal and Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs: IHS, tribal programs funded under P.L. 93-638 or Buy Indian contractors funded pursuant to 25 U.S.C. 47, or Title V (P.L. 94-437) urban Indian programs. In FY 1999,

Section 110 grants were made to the Northwest Portland Area Indian Health Board, the Dallas Inter-Tribal Center, the Fallon Paiute-Shoshone Tribe, the Greenville Rancheria Tribal Health Program, the Houlton Band of Maliseet Indians, the Nisqually Indian Tribe, and the Tanana Chiefs Conference, Inc. The project period for these grants ends July 31, 2002.

Section 112 authorizes the IHS to provide competitive grants to:

1. Public or private schools of nursing, tribally controlled community colleges, and tribally controlled post secondary vocational institutions (as defined in Section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397(h)(2)); and

2. Nurse midwife and nurse practitioner programs provided by any public or private institutions.

In FY 1999, awards were made to the Arizona State University, the Salish Kootenai College, the University of North Dakota at Grand Forks, and the University of Wisconsin at Eau Claire, the University of Oklahoma, the Sisseton-Wahpeton College, and the University of South Florida. These grants will be recompeted in 2003.

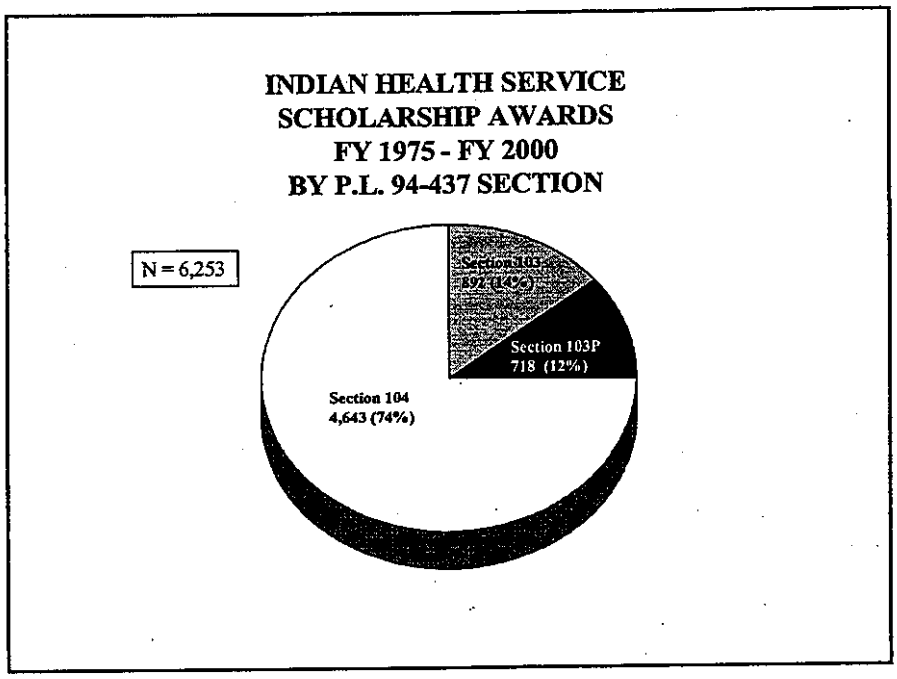
Section 114 authorizes the IHS to provide competitive grants to colleges and universities for the purpose of maintaining and expanding Native American health careers programs known as the Indians into Medicine Program (INMED). In FY 1998 the funded INMED programs at the University of North Dakota at Grand Forks and the University of Minnesota at Duluth. The University of Minnesota grant will expire in FY 2001 and be re-competed.

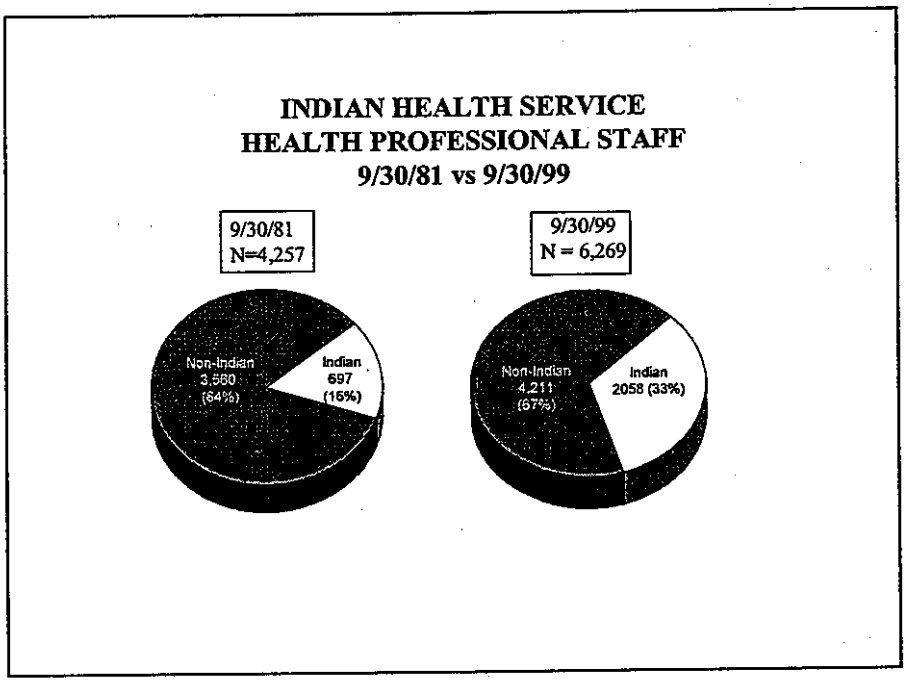
Section 120 authorizes the use of up to 5 percent of funds from Section 104 for competitive grants to tribes and tribal organizations to assist them in educating Indians to serve as health professionals in Indian communities. In FY 1999, Section 120 grants were made to the Chippewa Cree Tribe, the Ketchikan Indian Corporation, the Shingle Springs Rancheria, the Southcentral Foundation, and the Eastern Band of Cherokee. These grants will be re-competed in 2002.

Section 217 authorizes the IHS to provide competitive grants to colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/AN to enter the mental health field. In FY 1996, the University of North Dakota American Indians into Psychology Program was named in the authority and awarded a grant. Additional funds were appropriated in the amount of $600,000 for FY 1999. Of this amount, the Congress earmarked $200,000 for the University of Montana and through the competitive grant process Oklahoma State University was also awarded a grant. The project period for these grants ends July 31, 2001.

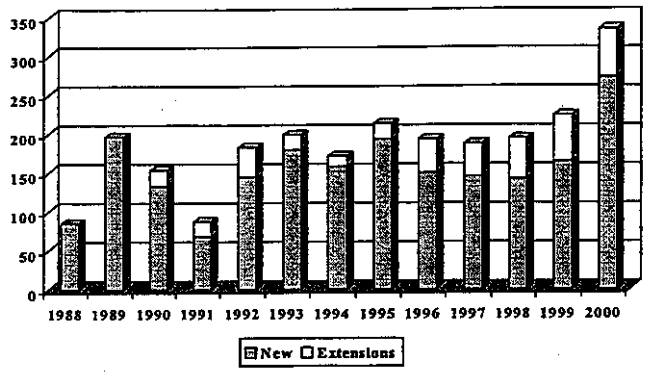
ACCOMPLISHMENTS

The following graphs illustrate the accomplishments of the scholarship and loan repayment programs over their years of existence.





Indian Health Service Loan Repayment Program
Awards by Fiscal Year
Fiscal Years 1988-2000



As the graphs show, over the period of its existence, the IHS Scholarship Program has made more than 6,000 awards, 74 percent of which were to students in their professional studies (Section 104). From 9/30/81 to 9/30/1999, total IHS professional staff grew by 47 percent while Indian professional staff grew by 195 percent. The proportion of professional staff that is Indian increased by 106 percent over that same period. It is certain that the vast majority of these Indian professionals were scholarship recipients.

The Loan Repayment Program's (LRP) contribution to IHS staffing has been as both recruitment and a retention tool. Professionals are attracted to the IHS because of the LRP, stay beyond the required two-year period in order to have a larger proportion of their loans repaid, as evidenced by the increasing number of extensions over the years, and remain in Indian health programs after their obligations are completed.

It is important to note that the data presented above do not include scholarship recipients who are employed outside the IHS. This information is not available to us at this time. If this information were available, the numbers of Indian professionals working in Indian health programs would surely be much larger.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$28,270,000	50	
1998	$28,720,000	16	
1999	$29,623,000	16	
2000	$30,491,000	20	
2001	$30,486,000	20	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $30,565,000 and 20 FTE is an increase of $79,000 over the FY 2001 enacted level of $30,486,000 and 20 FTE. The increases are as follows:

Built-in Increases - +$79,000

The request of $79,000 for Federal personnel-related cost would fund the built-in increases associated with on-going operations. Included are the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service for American Indians and Alaska Natives. The IHS patient population is affected disproportionately by chronic diseases such as diabetes access to health care than the general U.S. population. A continued support for current services is essential to ensure continuity in care the basic health care that is provided.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
TRIBAL MANAGEMENT

Program Authorization:

Program authorized by Indian Self Determination and Education Assistance Act, P.L. 93-638, as amended, Sections 103(b)(2) and 103(e) P.L. 100-472, P.L. 100-472 and P.L. 103-413.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$2,411,000	$2,406,000	$2,406,000	-$5,000	$0

PURPOSE AND METHOD OF OPERATION

Public Law 93-638, the Indian Self-Determination Act of 1976, authorized funding to develop the capacity of tribes to manage health care programs. In October 1988, Congress passed P.L. 100-472, the Indian Self-Determination Act Amendments to facilitate and simplify the process by which tribes and tribal organizations may assume management responsibility of IHS programs. In October 1994, Congress passed P.L. 103-413, the Indian Self-Determination Act Amendments, reaffirming maximum participation of Indian Tribes in programs, services, functions, and activities conducted by the Federal Government for Indians. The Amendments provide for a non-contracting "model agreement" to encourage and support the right of Indian Tribes to control and operate their own health programs.

Since FY 1988, these funds have been distributed through the Tribal Management Program for American Indians and Alaska Natives. This national grant program competitively awards tribal management funds to tribes and tribal organizations for 1) planning and 2) the development or improvement of tribal health management structures, including strengthening weaknesses in tribal management systems and developing effective health strategies for tribal programs and tribal staff.

ACCOMPLISHMENTS

Over the last 25 years, tribal operations of health programs have steadily increased and in FY 2000 represented $1.1 billion of the IHS budget. In FY 1988, fifty tribes and tribal organizations received tribal management grants; since then, the IHS has steadily increased participation in the grant program. As of FY 2000, 276 tribes and 63 Alaska Native villages had received tribal management grants. In FY 2000, Indian tribes operated 53 percent of the IHS service budget. The enactment of P. L. 103-413, the Indian Self Determination Act Amendments of 1994 offers tribes and tribal organizations attractive new opportunities in the assumption of the IHS programs. In FY 2000,

25 new grants and 7 continuation grants were awarded to tribes and tribal organizations.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	
1997	$2,348,000	
1998	$2,348,000	
1999	$2,390,000	
2000	$2,411,000	
2001	$2,406,000	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The request of $2,406,000 for this competitive grant activity will enable IHS to continue to assist tribes to build their tribal management activity.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
DIRECT OPERATION

Program Authorization:

Program authorized by U.S.C. 13, Snyder Act, and P.L. 83-568, Transfer Acts, 42 U.S.C. 2001.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$50,988,000	$52,946,000	$65,323,000	+$14,335,000	+$12,377,000
FTE	1,629	1,629	1,629	0	0

PURPOSE AND METHOD OF OPERATION

Executive direction, program management and administrative support constitute critical elements in the delivery of health care to AI/AN. No unit of health service is delivered without substantial program management and administrative support from different disciplines, i.e., health assessment, policy development, finance, procurement, program evaluation, supply management, personnel, equipment, training, etc.

The many unusual circumstances relating to the direct delivery of health services to AI/AN require the adoption of special management principles and accompanying organizational structure. IHS has substantially increased its tribal consultation activities in recent years. As more tribes contract or compact to manage their own health programs, IHS has provided more technical assistance to tribes. This requires an additional dimension of administrative and program management expertise not ordinarily encountered in other Federal programs. An understanding of the way that the IHS provides, directly and indirectly through Tribal and Urban Indian health programs, a vast array of services to the diverse and dispersed AI/AN populations is important in order to appreciate the management, oversight, and tribal consultation and their direct influence on budget formulation and execution activities.

In response to these functions, the IHS has structured its organization, delegated the necessary authorities and assigned the appropriate management responsibilities in three principal levels: (1) national (Headquarters); (2) regional (Area Office); and (3) local (Service Unit or facility). This structure allows effective programmatic oversight, local management, and tribal consultation at any level, while capitalizing on the economies of scale made possible by collaborative or aggregate activities. The functions of each level are unique, interrelated, and complementary to assure an uninterrupted execution of program and administrative management. To the greatest extent practicable and feasible, the delegation of authorities at the community level has and will enable timely decisions in patient care.

Headquarters

The Headquarters provides essential integration at the national level, assuring consistency of policy and practice across the many diverse locations served by IHS. For example, without this integration, it would be impossible to address the issue of equity and ensure the integrity at a national comprehensive healthcare delivery system. Headquarters carries out national functions, including the responsibilities of a Federal Agency such as establishment, implementation, and oversight of program and administrative policy, strategic and operational planning, budget formulation and execution, administrative control of funds, Federal Managers Financial Integrity Act (FMFIA), Government Performance and Results Act (GPRA), procurement, facilities construction planning, and many related functions in compliance with applicable laws and regulations.

Headquarters staff, through two principal offices of management support and public health, advise and support the Director on programmatic and administrative issues, and respond to the many and diverse requests that come to the Agency from the Department, OMB, the Congress, and other Federal Agencies. Headquarters personnel also monitor, coordinate, and evaluate Area and local activities and programs to ensure conformance with congressional and other directives. They manage certain Nation-wide support functions such as the catastrophic health emergency fund, health facilities construction, and grant programs that make awards to tribes, urban Indian health programs, Indian organizations, and individuals, for purposes such as diabetes prevention and treatment, the development or enhancement of management infrastructure to permit tribes to manage health programs, the education of health professionals who will work in Indian communities, and the retention of health professionals by assisting with the repayment of student loans. Additionally, Headquarters personnel provide information and reports to the Congress and the Executive Branch, technical assistance to tribes and Areas, and act in an advocacy and leadership role with other Federal agencies, professional associations, and other entities that may contribute to fulfilling the IHS mission.

Area Offices

Area Offices are responsible for carrying out a dual function: (1) to participate in and establish goals and objectives implementing IHS policies, and determine priorities for action within the framework of IHS policy. As such, Area Offices coordinate their respective activities and resources internally and externally with those of other governmental and non-governmental programs to promote optimum utilization of all available health resources. The burden of negotiating, consulting, and participating with the approximately 550 sovereign Indian nations rests primarily with the Area Offices which must work in partnership with the Indian nations while remaining agents of the Federal government. And, (2) ensure the delivery of quality health care through their respective service units and participate in the development and demonstration of alternative means and techniques of health services management and delivery to provide Indian tribes and other Indian community groups with optimal ways of participating in Indian health programs. As an integral part of this dual function, the Area Offices are principally responsible for assuring the development of individual and tribal capabilities to participate in the operation of the IHS program as deemed appropriate by the tribes.

ACCOMPLISHMENTS

Self-Governance Authority

In FY 1993 and 1994, the Indian Health Service implemented a demonstration program in Tribal Self-Governance and negotiated with tribes the first 14 compacts and annual funding agreements. After the necessary policies and decisions regarding financial allocation were developed and implemented, Congress made Tribal Self-Governance Authority permanent in FY 2000. In FY 2001, we anticipate that $642 million will be transferred to support 48 compacts with tribes.

Organizational Change

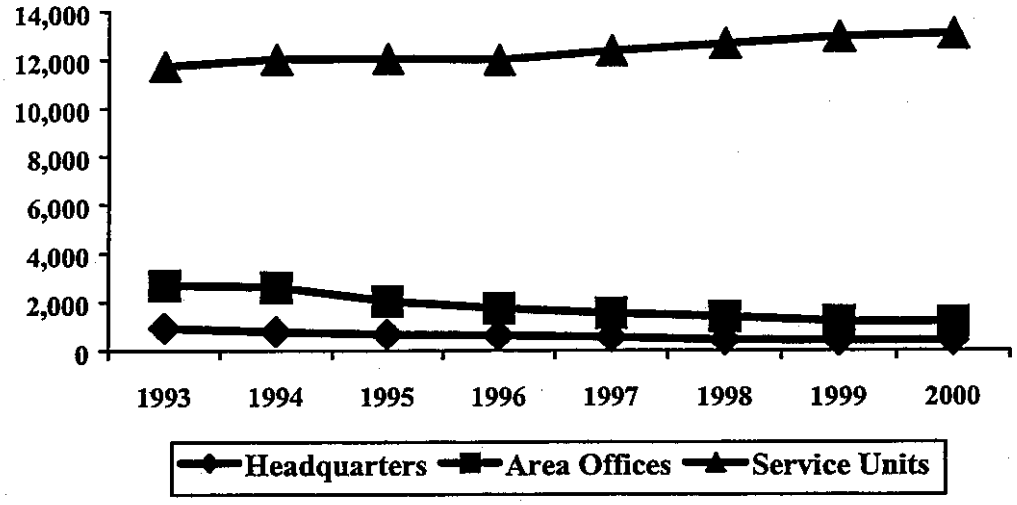
Significant changes have occurred in the Indian Health Service in recent years. Changes were necessary to ensure a structure and staffing sufficient to carry out inherent Federal functions while maximizing efficiency in management and administration to permit the shift of resources to the point of health service delivery, including federal service units and tribal health programs.

Major changes to the function and structure of the Indian Health Service Headquarters were implemented in FY 1997, as recommended by the Indian Health Design Team. Significant reductions in organizational size and complexity were achieved as nine Headquarters offices were reduced to three, and 137 Staff Offices, Divisions, Branches, and Sections were consolidated into 31 Divisions and Staff Offices. These changes eliminated the need for six Associate Directors and their Deputies, as well as three Division/Staff Directors, and 99 Branch/Section Chiefs.

Since 1997, the Aberdeen, Albuquerque and California Area Office have also restructured and streamlined their organizations. Changes in these Areas eliminated six Associate Offices, and 12 Staff Groups or Sections and the corresponding requirement for Division and Staff Directors and Branch Chiefs.

An IHS workforce report indicates that at the end of FY 2000, The Indian Health Service had 14,656 FTE on board. However, 1,359 of the FTE were assigned to tribes through Inter-Governmental Act Assignments or Memoranda of Agreement. Such agreements are important to achieving self-determination, as they minimize recruitment problems at the time of the transfer of programs to the tribes. Continued Federal support through Direct Operations includes such costs as payroll processing and workman's compensation for FTE assigned to tribes.

Indian Health Service Employment: 1993 - 2000
Service Units Increased While Area Offices and Headquarters Decreased



IHS Business Plan

Concurrent with organizational changes, the Indian Health Service shifted to a corporate-oriented approach to conducting business. The Indian Health Service developed, together with Indian leaders, a business plan to adopt more business-like planning and practices in key segments of Indian Health Service operations. The plan set a course for management that has resulted in important accomplishments and enhanced stewardship of important resources.

First, the Indian Health Service launched a hospital cost report initiative that has helped Indian Health Service more accurately identify its hospital cost and set higher reimbursement rates for patients with Medicare, Medicaid, and or private insurance coverage. In addition, the Indian Health Service has improved its systems to identify third party eligibility, document services provided, and automate third party billing and tracking. These business initiatives have been instrumental in helping the Indian Health Service to increase third-party collections by almost $150 million, or 59%, between FY 1996 and FY 2000. In addition, Area Offices have negotiated with contract-providers, Medicare-like rates to make Contract Health Service dollars go farther, refinements to the Contract Support Cost Policy have reduced the potential for paying duplicate costs, and current efforts to link billing with accounts receivable hold the promise of strengthening internal management and operations.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$48,709,000	510	
1998	$47,386,000	465	
1999	$49,309,000	434	
2000	$50,988,000	1,629	
2001	$52,946,000	1,629	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $65,323,000 and 1,629 FTE is the increase of $12,377,000 over the FY 2001 enacted level of $52,946,000 and 1,629 FTE. The increase is as follow:

Built-in Increases - +$2,377,000

The request of $406,000 for inflation/tribal pay cost and $1,971,000 for Federal personnel related cost would fund the built-in increases associated with on-going operations. Included are the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

IHS continues to strive to increase access to the IHS patient population. It is extremely critical that the IHS maintains the FY 2001 level of service to prevent any further decline in primary health services. Maintaining the current I/T/U health systems is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Federal Cost of Navajo Conversion: +$10,000,000

A recent proposal from the Navajo Nation to contract for the programs now administered through the Navajo Area Office and eight service units has created a critical and unprecedented request for funding to pay costs that will occur as a result of entering into a single P.L. 93-638 contract. As many as 4,000 Federal positions in the Navajo Area could be affected in FY 2002. Funds will be needed for severance pay for those employees the tribe does not wish to retain. Incentives for early retirement will also be offered in order to reduce the need for reduction-in-force. Although the funds are requested in Direct Operations, they would be available for the costs of displaced IHS employees whose salaries are paid out of other budget line items (e.g., Hospitals and Health Clinics). In addition, this contract can reasonably be expected to impact other Indian Health Service Areas. For example, the Albuquerque and Phoenix Areas currently provide services for a large number of Navajo patients. These Areas may find that changes in workload require changes in staffing as this new P.L. 93-638 contract is implemented.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
SELF GOVERNANCE

Program Authorization:

Program authorized by Title V, Tribal Self-Governance, P.L. 93-638, Indian Self Determination Act, as amended.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$9,531,000	$9,803,000	$9,876,000	+$345,000	+$73,000
FTE	9	9	9	0	0

PURPOSE AND METHOD OF OPERATION

In FY 1992, IHS was instructed by Congress to initiate planning activities with tribal governments with approved Department of Interior self-governance compacts for the development of a Self-Governance Demonstration Project as authorized by P.L. 100-472. Through enactment of P.L. 102-573, the Indian Health Care Amendments of 1992, authority to fund the tribal self-governance demonstration projects (SGDP) was extended to IHS and the Office of Tribal Self-Governance was established. Through enactment of P.L. 106-260, the Tribal Self-Governance Amendments of 2000, permanent authority was given to Title V, Tribal Self-Governance. Since 1993, the IHS, in conjunction with Tribal representatives, has been engaged in a process to develop methodologies for identification of Tribal shares for all Tribes. Tribal shares are those funds historically held at the Headquarters and Area organizational levels of the IHS. In FY 2002, approximately $717 million will be transferred to support 63 compacts.

ACCOMPLISHMENTS

Tribes participating in the Tribal Self-Governance Program (TSGP) report that the program has had a significant positive impact on the health and well being of their constituents. The TSGP puts the administration and management of the health programs in the hands of tribal governments and provides them the flexibility to tailor their health programs to meet the diverse and unique needs of their constituents. Significant improvements have been made in the administration of Tribal health programs and in the quality, quantity and accessibility of services provided the service population. Thus federal funds are more effectively and efficiently used in addressing the local health needs of American Indians and Alaska Natives. The TSGP also promotes improved program and fiscal accountability in that tribal governments and health administrators are held directly accountable by and to their service population. A study conducted by the National Indian Health Board confirmed the significant positive impact that Self-Governance has had on Tribal health programs and their constituents.

in addressing the local health needs of American Indians and Alaska Natives. The TSGP also promotes improved program and fiscal accountability in that tribal governments and health administrators are held directly accountable by and to their service population. A study conducted by the National Indian Health Board confirmed the significant positive impact that Self-Governance has had on Tribal health programs and their constituents.

The following are examples of the TSGP's positive impact enjoyed by self-governance tribes. It is not an all-inclusive list but rather an example of what can be accomplished through the TSGP.

- Several Self-Governance Tribes have developed goals for its health program and met them in the following manner:

  - **To Increase The Accessibility Of Health Services:**

    - New health clinic, 7128 sf facility provides multiple health care services: primary care, prevention, education, immunizations, maternal & child health, Community Health, Public Health Nurse, WIC, Pharmacy, Radiology, Dental, Optometry Screening, Substance and Alcohol Screening are provided.

    - The new Choctaw Nation Health Center, in Talihina, Oklahoma, features 37 hospital inpatient beds and 52 rooms in the clinic for outpatients. The new hospital replaced a facility that was constructed almost 70 years ago. This is the first Tribe to construct their own hospital.

  - **To Improve Health Status through Patient Awareness and the Promotion of Wellness:**

    - Wellness Center, a 10,950 sf facility that houses a 32x75',25 yard therapeutic exercise indoor swimming pool opened June 1999. Programs implemented area fitness assessments, water aerobics, recreational swimming, lap swimming, personal weight training, Healthy Eating & Learning program, also diabetic nutritional and educational classes, foot care clinic and shoe sizing are programs offered at the Wellness Center.

    - NSHC - all health aides in our region were trained in the use of the revised and updated Community Health Aide Manual and were using it.

    - Provided two continuing medical education classes and one re-entry/remedial training for eight health aides.

    - Forty-one health aides participated in emergency trauma technician or emergency medical technician training during the year in conjunction with the EMS department.

- **The quality of health care and health services provided by Tribal governments has been recognized by other Agencies and professional organizations:**

  - The AST clinic was re-accredited for an additional three-year period after a JCAHO team conducted an on-site survey and determined that the clinic operation is in compliance with JCAHO quality standards for ambulatory care organizations. "Achieving accreditation demonstrates the AST commitment to consistently provide very high quality care to its patients."

  - MBCI advised that they have received a score of 96 out of a 100 from the JCAHO for their hospital.

- **To increase the efficiency and the quality of services of the health system:**

  - A quality assurance project for contract health services was also completed to improve the quality of and necessity of care purchased from community sources.

  - A second physician was added to the clinic staffing which brings the total number of full times providers to three.

  - The health center facility continued its efforts to become certified by the JCAHO with plans for a survey during 2000.

  - The Choctaw Nation initiated the Foster Grandparents Program at Jones Academy to improve the lives of the students. Volunteers from the community help the younger children each day with homework and greet the youngsters each day when they get off the bus and stay with them until after supper.

- **To provide community prevention plans including traditional and spiritual healing methods that reduce the need for more remedial type of treatment programs:**

  - Conduct Tribal gatherings at least once a year. Events such as the Intertribal Men's gathering, the Women and Girl's Gathering, and the Intertribal bike tour are held annually.

  - Develop/Conduct health promotion programs and related workshops. The Health Center has hosted workshops on topics such as Pregnancy Prevention, Sexually transmitted Diseases, Healing from Trauma, Car seat and Bicycle Helmet Safety, and Aroma Therapy.

  - Incorporate more traditional methods of healing into programs. Therapeutic healing while participating in

basket or drum making classes or attending talking circles is proving effective.

- **The current design of another TSGP tribe the Health Services Program serves is:**

  - Monthly Men's Breakfast. It is often difficult to engage Tribal men in health programs. The monthly breakfast acts as a support and educational meeting for men who otherwise would have little contact with the health programs.

  - Cost containment for the Elders Prescription Drug Program. Drug costs have been rising rapidly. To ease this increase, the Medical Director reviewed high cost drugs and implemented several cost saving changes including an educational strategy to Tribal members and pharmacists to substitute equivalent less expensive generic drugs.

  - Development of Business and Billing Capacity for Chemical Dependency Program. This program has been able to implement a system to effectively collect third party revenue for services.

- **The programs developed by a TSGP tribe the Health Services Program serves continue:**

  - Smoking cessation programs - support group continues to meet weekly is advertised through word of mouth and newsletter articles every month. Nicotine patches are also available to smokers who request them.

  - Dental prevention program - brushing, flossing, and toothbrush distribution; a communication system is in place so individuals who require routine prophylaxis are identified and routinely scheduled with a contracted dentist.

  - Massage Therapy for Elders - to accommodate this service without additional funding, an arrangement was made with Peninsula College to use the Tribal Center as massage therapy training site. The elders say massage therapy increases their mobility, reduces their stress and acts as a good augment to the water walking class.

Fiscal Year 2001 Compacts as Funded

FY 2001 IHS Self-Governance Compacts					
Compacts by State	FY 2001 Compact Amounts				
	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alaska	**$260,423,000**	**$14,193,000**	**$17,058,000**	**$54,344,000**	**$346,018,000**
Alaska Native Tribal Health Consortium	$69,427,000	$11,787,000	$2,504,000	$5,271,000	$88,989,000
Aleutian/Pribilof Islands Association, Inc.	$1,769,000	$19,000	$187,000	$479,000	$2,454,000
Arctic Slope Native Association	$5,804,000	$47,000	$888,000	$2,162,000	$8,901,000
Bristol Bay Area Health Corporation	$15,902,000	$287,000	$1,539,000	$4,531,000	$22,259,000
Chugachmiut	$2,896,000	$25,000	$189,000	$1,001,000	$4,111,000
Copper River Native Association	$1,466,000	$8,000	$155,000	$509,000	$2,138,000
Council of Athabascan Tribal Government	$807,000	$2,000	$29,000	$412,000	$1,250,000
Eastern Aleutian Tribes, Inc.	$1,125,000	$11,000	$11,000	$259,000	$1,406,000
Ketchikan Indian Corporation	$3,106,000	$26,000	$718,000	$1,361,000	$5,211,000
Kodiak Area Native Association	$4,479,000	$34,000	$312,000	$1,161,000	$5,986,000
Maniilaq Association	$20,186,000	$209,000	$1,935,000	$6,450,000	$28,780,000
Metlakatla Indian Community	$1,987,000	$22,000	$107,000	$513,000	$2,629,000
Mount Sanford Tribal Consortium	$569,000	$1,000	$42,000	$178,000	$790,000
Native Village of Eklutna	$119,000	$1,000	$4,000	$19,000	$143,000
Norton Sound Health Corporation	$14,510,000	$175,000	$1,323,000	$3,752,000	$19,760,000
Seldovia Village Tribe	$586,000	$2,000	$16,000	$254,000	$858,000
Southcentral Foundation	$38,570,000	$214,000	$1,671,000	$6,691,000	$47,146,000
Southeast Alaska Regional Health Corporation	$26,630,000	$333,000	$2,221,000	$5,186,000	$34,370,000
Tanana Chiefs Conference	$20,811,000	$380,000	$1,125,000	$3,305,000	$25,621,000
Yukon-Kuskokwim Health Corporation	$29,674,000	$610,000	$2,082,000	$10,850,000	$43,216,000
Alabama	**$2,524,000**	**$122,000**	**$114,000**	**$551,000**	**$3,311,000**
Poarch Band of Creek Indians	$2,524,000	$122,000	$114,000	$551,000	$3,311,000

FY 2001 IHS Self-Governance Compacts					
Compacts by State	FY 2001 Compact Amounts				
	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
California	**$8,228,000**	**$282,000**	**$649,000**	**$3,430,000**	**$12,589,000**
Hoopa Valley Tribe	$3,009,000	$138,000	$183,000	$951,000	$4,281,000
Karuk Tribe of California	$1,605,000	$57,000	$66,000	$864,000	$2,592,000
Redding Rancheria	$3,614,000	$87,000	$400,000	$1,615,000	$5,716,000
Connecticut	**$983,000**	**$1,000**	**$0**	**$32,000**	**$1,016,000**
Mohegan Tribe of Indians of Connecticut	$983,000	$1,000	$0	$32,000	$1,016,000
Florida	**$4,032,000**	**$106,000**	**$192,000**	**$812,000**	**$5,142,000**
Seminole Tribe of Florida	$4,032,000	$106,000	$192,000	$812,000	$5,142,000
Idaho	**$8,965,000**	**$689,000**	**$756,000**	**$1,276,000**	**$11,686,000**
Coeur D'Alene Tribe	$3,375,000	$302,000	$454,000	$718,000	$4,849,000
Nez Perce Tribe	$5,590,000	$387,000	$302,000	$558,000	$6,837,000
Louisana	**$776,000**	**$65,000**	**$34,000**	**$111,000**	**$986,000**
Chitimacha Tribe of Louisana	$776,000	$65,000	$34,000	$111,000	$986,000
Maine	**$2,213,000**	**$128,000**	**$128,000**	**$536,000**	**$3,005,000**
Penobscot Indian Nation	$2,213,000	$128,000	$128,000	$536,000	$3,005,000
Massachusetts	**$441,000**	**$50,000**	**$158,000**	**$118,000**	**$767,000**
Wampanoag Tribe of Gay Head	$441,000	$50,000	$158,000	$118,000	$767,000
Michigan	**$8,740,000**	**$692,000**	**$589,000**	**$1,314,000**	**$11,335,000**
Grand Traverse Band of Ottawa and Chippewa Indian	$1,703,000	$250,000	$45,000	$467,000	$2,465,000
Sault Ste. Marie Tribe of Chippewa Indians	$7,037,000	$442,000	$544,000	$847,000	$8,870,000
Minnesota	**$7,852,000**	**$596,000**	**$354,000**	**$1,003,000**	**$9,805,000**
Bois Forte Band of Chippewa Indians	$1,605,000	$122,000	$54,000	$283,000	$2,064,000
Fond du Lac Band of Lake Superior Chippewa	$4,578,000	$296,000	$248,000	$488,000	$5,610,000
Mille Lacs Band of Ojibwe	$1,669,000	$178,000	$52,000	$232,000	$2,131,000

FY 2001 IHS Self-Governance Compacts					
	FY 2001 Compact Amounts				
Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Mississippi	**$10,206,000**	**$822,000**	**$937,000**	**$1,750,000**	**$13,715,000**
Mississippi Band of Choctaw Indians	$10,206,000	$822,000	$937,000	$1,750,000	$13,715,000
Montana	**$20,598,000**	**$887,000**	**$1,463,000**	**$2,318,000**	**$25,266,000**
Chippewa Cree Tribe of the Rocky Boy's Reservation	$6,740,000	$398,000	$890,000	$990,000	$9,018,000
Confederated Salish and Kootenai Tribes of Flathead	$13,858,000	$489,000	$573,000	$1,328,000	$16,248,000
Nevada	**$6,373,000**	**$636,000**	**$737,000**	**$2,028,000**	**$9,774,000**
Duck Valley Shoshone-Paiute Tribe	$4,839,000	$577,000	$549,000	$1,523,000	$7,488,000
Duckwater Shoshone Tribe	$731,000	$34,000	$143,000	$278,000	$1,186,000
Ely Shoshone Tribe	$803,000	$25,000	$45,000	$227,000	$1,100,000
Oklahoma	**$102,463,000**	**$7,612,000**	**$6,264,000**	**$17,003,000**	**$133,342,000**
Absentee Shawnee Tribe of Oklahoma	$2,791,000	$214,000	$581,000	$487,000	$4,073,000
Cherokee Nation	$28,369,000	$1,412,000	$1,113,000	$3,388,000	$34,282,000
Chickasaw Nation	$28,649,000	$2,054,000	$1,563,000	$5,865,000	$38,131,000
Choctaw Nation of Oklahoma	$30,120,000	$3,322,000	$2,051,000	$3,567,000	$39,060,000
Citizen Potawatomi Nation	$3,783,000	$278,000	$566,000	$1,191,000	$5,818,000
Kaw Nation	$581,000	$64,000	$142,000	$200,000	$987,000
Kickapoo Tribe of Oklahoma	$2,316,000	$115,000	$111,000	$1,151,000	$3,693,000
Modoc Tribe of Oklahoma	$39,000	$0	$4,000	$35,000	$78,000
Ponca Tribe of Oklahoma	$2,207,000	$60,000	$15,000	$424,000	$2,706,000
Sac and Fox Nation	$2,679,000	$23,000	$92,000	$454,000	$3,248,000
Wyandotte Nation	$929,000	$70,000	$26,000	$241,000	$1,266,000
Oregon	**$9,700,000**	**$479,000**	**$1,365,000**	**$4,003,000**	**$15,547,000**
Coquille Indian Tribe	$1,186,000	$50,000	$167,000	$649,000	$2,052,000
Confederated Tribes of Grand Ronde	$4,315,000	$280,000	$659,000	$2,210,000	$7,464,000
Confederated Tribes of Siletz Indians of Oregon	$4,199,000	$149,000	$539,000	$1,144,000	$6,031,000

FY 2001 IHS Self-Governance Compacts					
Compacts by State	FY 2001 Compact Amounts				
	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Washington	**$17,289,000**	**$1,505,000**	**$1,175,000**	**$7,058,000**	**$27,027,000**
Jamestown S'Klallam Indian Tribe	$635,000	$30,000	$66,000	$273,000	$1,004,000
Lummi Indian Nation	$4,455,000	$423,000	$186,000	$1,432,000	$6,496,000
Makah Indian Tribe	$447,000	$106,000	$36,000	$159,000	$748,000
Nisqually Indian Tribe	$1,335,000	$82,000	$83,000	$478,000	$1,978,000
Port Gamble S'Klallam Tribe	$1,200,000	$147,000	$103,000	$422,000	$1,872,000
Quinault Indian Nation	$3,389,000	$468,000	$166,000	$1,775,000	$5,798,000
Shoalwater Bay Indian Tribe	$1,309,000	$40,000	$161,000	$435,000	$1,945,000
Squaxin Island Indian Tribe	$1,818,000	$140,000	$149,000	$924,000	$3,031,000
Suquamish Tribe	$1,018,000	$46,000	$112,000	$467,000	$1,643,000
Swinomish Indian Tribal Community	$1,683,000	$23,000	$113,000	$693,000	$2,512,000
Wisconsin	**$5,729,000**	**$471,000**	**$224,000**	**$546,000**	**$6,970,000**
Oneida Tribe of Indians of Wisconsin	$5,729,000	$471,000	$224,000	$546,000	$6,970,000
Grand Total	**$477,535,000**	**$29,336,000**	**$32,197,000**	**$98,233,000**	**$637,301,000**

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$9,106,000	6	
1998	$9,106,000	6	
1999	$9,391,000	7	
2000	$9,531,000	7	
2001	$9,803,000	8	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $9,876,000 and 9 FTE is an increase of $73,000 over the FY 2001 enacted level of $9,803,000 and 9 FTE. The increases are as follows:

Built-in Increases - +$73,000

The request $73,000 for Federal personnel related cost would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service to American Indians & Alaska Natives. Maintaining the current I/T/U health system to ensure access and continuity of care is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

2001 Self-Governance Annual Funding Agreements

By Areas

Area	Tribal User Pop	At Large User	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Alaska	96,385	11,865	257,106,000	10,288,000	7,222,000	17,058,000	54,344,000	346,018,000
Aberdeen	0	0	0	118,000	0	0	0	118,000
Bemidji	25,099	0	20,841,000	1,882,000	1,239,000	1,167,000	2,863,000	27,992,000
Billings	13,147	0	18,411,000	1,773,000	1,301,000	1,463,000	2,318,000	25,266,000
California	6,893	5,864	7,209,000	849,000	452,000	649,000	3,430,000	12,589,000
Nashville	14,481	0	19,225,000	2,498,000	746,000	1,563,000	3,910,000	27,942,000
Oklahoma	182,700	38,936	96,779,000	6,385,000	6,911,000	6,264,000	17,003,000	133,342,000
Phoenix	1,882	0	6,546,000	284,000	179,000	737,000	2,028,000	9,774,000
Portland	28,912	0	33,626,000	2,962,000	2,039,000	3,296,000	12,337,000	54,260,000
Total, IHS	369,499	56,665	459,743,000	27,039,000	20,089,000	32,197,000	98,233,000	637,301,000

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services - 75-0390-0-1-551
CONTRACT SUPPORT COSTS

Program Authorization:

Program authorized by P. L. 93-638, Indian Self-Determination Act, as amended and P. L. 100-472, Section 106(a)(2) A & B.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$228,781,000	$248,234,000	$288,234,000	+$59,453,000	+$40,000,000

PURPOSE AND METHOD OF OPERATION

Section 106(a)(2) of P.L. 93-638, the Indian Self-Determination Act, as amended, authorizes the Secretary to fund those costs that a tribal contractor incurs in addition to what the Secretary would have otherwise provided for the direct operation of the program. These costs are referred to as contract support costs.

The IHS uses contract support cost funds made available under the ISD fund to support the initial transfer of programs from Federal operations to tribal operation. The ISD funds tribal requests that include Start-Up, Direct, and Indirect types of Contract Support Costs.

Amounts needed for Indirect CSC are determined in independent negotiations with the cognizant Agency's Inspector General (which is the Department of the Interior for virtually all contracts). The types of costs included in these indirect cost pools include the reasonable costs of tribal governing bodies, management and planning, financial management, property management, procurement management, data processing, office support, building rent, utilities, program specific insurance, legal services, and single-agency audits.

ACCOMPLISHMENTS

Contract support costs (CSC) is a supplement to the direct program funding provided in order to maintain an equitable opportunity for tribes who choose to operate programs under this legislative authority.

In 1997, the Congress directed the IHS to "work with Tribes, the Bureau of Indian Affairs and the Inspector General at the Department of the Interior to contain the escalation in contract support costs." In response to this directive, the IHS developed a "Report to Congress on Contract Support Cost Funding in Indian Self-Determination Contracts and Compacts". The findings of the report, based on analysis of tribal indirect cost rates, indicated that rates have remained relatively stable and have not unreasonably escalated. The report further indicated that the continued increase in contract support cost need is due primarily to the increased assumption by tribes of new programs, services, functions and activities from the IHS.

The Office of the Inspector General within the Department of Interior reached a similar conclusion as a result of an analysis it conducted of a sample of tribes over an eight-year period.

In FY 1999, the IHS received a $35 million increase for CSC. Recommendations from the tribal consultation process resulted in the adoption of an allocation methodology that distributed CSC to those tribes with the greatest overall CSC need. The distribution of the $35 million increase in this manner resulted in the IHS being able to fund contracting/compacting tribes at an average level of 86 percent for CSC. No tribe in the IHS system was funded at less than 80 percent of its CSC costs at the time the $35 million was allocated.

Consultation with tribes also resulted in the adoption of a new policy in FY 2000 to govern the administration of CSC in the IHS. The policy implements a new process and methodology for distributing CSC within available resources to tribes for new assumptions of programs, functions, services and activities. The policy also implements a process and methodology for reducing the inequity in CSC funding for existing contract and compact tribes.

In FY 2000, the IHS received a $25 million increase for CSC. The same allocation methodology used in FY 1999 was used in FY 2000 to allocate this increase. The continuation of distribution of the $25 million increase in this manner resulted in the IHS being able to fund contracting/compacting tribes at an average level of 94 percent for CSC. No tribe in the IHS System was funded at less than 90 percent of its CSC costs at the time the $25 million was allocated. This is an increase of 8 percent in the average level funded and a 10 percent increase over the minimum funding level from the previous year. This increase in the level funded and the increase in the minimum funding level is a direct result of the IHS working with Tribes to contain ongoing program contract support costs and the promotion of consistency throughout the IHS system in the types of CSC awarded by the Agency for new and expanded programs.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$160,702,000	--	
1998	$168,702,000	--	
1999	$203,781,000	--	
2000	$228,781,000	--	
2001	$248,234,000	--	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $288,234,000 is the increase of $40,000,000 over the FY 2001 enacted level of $248,234,000. The increases are as follows:

Contract Support Cost for New and Expanded Contracts - +$40,000,000

To date, the Navajo Nation has submitted a proposal to contract for the operation of all of the health services. The IHS currently provides for the Navajo Nation's 250,000 citizens. These services include 6 hospitals and 19 outpatient facilities with an FY 2001 budget of $349 million. Funds are

requested to provide Contract Support Costs primarily for the Navajo Nation, and for other tribes' new or expanded contracts in FY 2002.

The additional $40 million will be used for new and expanded contract based upon IHS distribution policy. This policy gives priority to Tribes with the greatest relative need for contract support funding (i.e., contract support cost funding from existing contracts compared to the amount of contract support cost from the new or expanded contract). Because the anticipated amount of contract support costs from the new Navajo contract are so much larger than the contract support costs it receives from existing contracts, IHS anticipates that most of the $40 million will be used for the new Navajo contract.

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ACTIVITY/MECHANISMS BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
DIABETES

Program Authorization:

Program authorized by 111 STAT. 574, 1997 Balanced Budget Act (P.L 105-33) and H.R. 4577, Consolidated Appropriation Act 2001 (P.L. 106-554) and Interior Appropriation IHS National Diabetes Program.

Indian Health

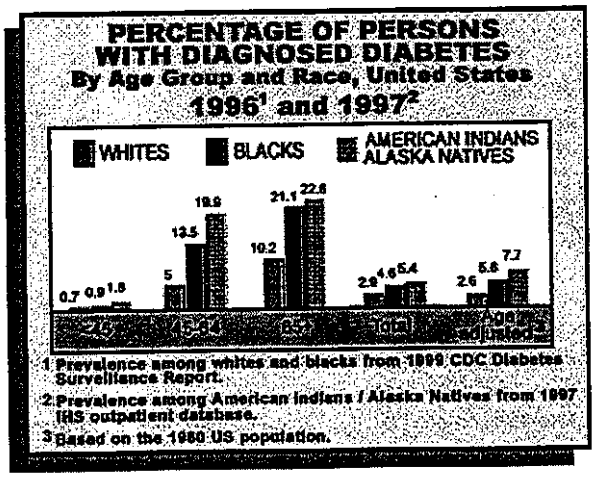
Diabetes	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$30,000,000	$100,000,000	$100,000,000	+$70,000,000	0

The Balanced Budget Act of 1997 (P.L. 105-33) provides that $30 million per year appropriated to the Children's Health Insurance Program be transferred to IHS for diabetes prevention and treatment. An additional $70,000,000/year was received under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 for FY 2001 and FY 2002, and $100,000,000 is available for FY 2003. Total IHS diabetes funding also includes the IHS National Diabetes Program with 12 Area Diabetes Consultants and 19 model diabetes sites ($7.7 million per year) and, starting in FY 1998, an annual $3 million in IHS diabetes grants and $.3 million for a periodontal disease project.

PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

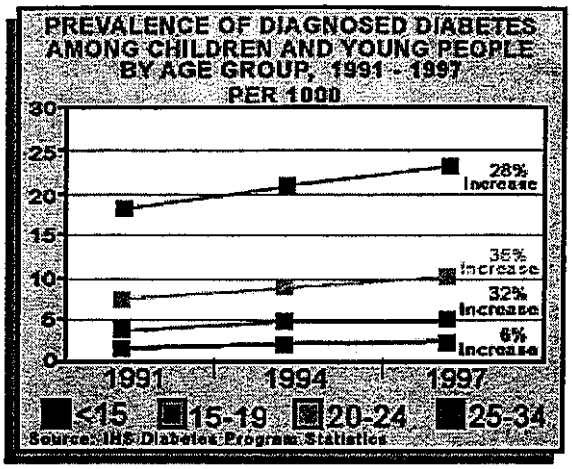
The mission of the IHS National Diabetes Program is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indian and Alaska Native. The agency promotes collaborative strategies for the prevention of diabetes and its complications in the 12 IHS Service Areas through a network of 19 Model Diabetes Programs and 13 Area Diabetes Consultants. The agency also disseminates current information about all aspects of diabetes surveillance, treatment, education, and prevention.



Diabetes was the most frequently identified health problem in the IHS Area I/T/U budget formulation workshops for FY 2001.

Type 2 diabetes occurs at dramatically higher rates among AI/AN adults who are almost 3 times more likely to have diabetes than the general U.S. population.

A recent alarming trend is the increase in prevalence of type 2 diabetes in young AI/AN. Over a seven-year period, from 1991-1997, the prevalence of diabetes rose 28-36 percent in AI/AN children and adolescents.



Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population. Most recent data show that diabetes mortality is 4.3 times higher in the AI/AN population than in the U.S. population. There has been a 24 percent increase in the American Indian age-adjusted death rate from diabetes since 1991-1993. There is clear evidence that for American Indian/Alaska Natives the health disparity related to diabetes is increasing.

The Balanced Budget Act (BBA) of 1997 provided $30 million per year for 5 years through the *Special Diabetes Program for Indians* (SDPI) to provide grants for the prevention and treatment of diabetes to Indian Health Service (IHS), tribal, and urban Indian health programs. The IHS completed a tribal consultation process on the approach to the provision of diabetes services in AI/AN communities. The process included national and regional input from tribal and urban program representatives.

A Tribal Leaders Diabetes Workgroup was established to review the tribal input and make recommendations on the administration and distribution of the BBA funds. Based on the Workgroup recommendations, funds were awarded through non-competitive grants for a five-year project term. The Workgroup recommended that IHS distribute the funding by IHS Area according to a formula based primarily on disease burden (53 percent) and user population with an adjustment to increase funding for very small tribes (42 percent). They also recommended that $1.5 million be set aside for the urban programs who were to be exempt from the distribution formula process. In addition, 5 percent of the overall funds were reserved for improved data collection to enhance the evaluation process. Distribution of the grant funds within each Area to local IHS and tribal programs was determined by an Area-wide consultation process. An evaluation process was created for both the national and Area levels.

There were 286 grants awarded in the first year cycle. Contracts with several tribal organizations were written at the national and regional level to enhance and facilitate evaluation and data collection activities. Ongoing evaluation of the grants, using a mixed methods approach (both qualitative and quantitative methods) has been implemented.

Tribal programs determined how their funding was to be used. Sixty six percent of programs chose to focus on both primary (such as offering exercise and nutrition programs to prevent the incidence of diabetes) and secondary (managing diabetes to prevent complications such as kidney failure, amputations, heart disease and blindness) diabetes prevention efforts. Thirty three percent of programs decided to implement tertiary prevention efforts to reduce morbidity and disability in those who have complications from diabetes. And forty one percent indicated the need for additional planning for their diabetes efforts. Chief Medical Officers, Area Diabetes Consultants and other IHS Area Office Staff were available to assist tribes in choosing promising prevention efforts and in selecting appropriate evaluation measures.

In addition to grants, $1 million of the BBA funds were allocated for the development of a National Diabetes Prevention Center (NDPC) in Gallup, NM. IHS collaborated with CDC Division of Diabetes in this effort. The NDPC agreement was awarded to the University of New Mexico who has established a Steering Committee and a Center Advisory Board. The Tribal Leaders Diabetes Committee, established as a result of the BBA funds to advise IHS on diabetes-related issues, will also advise the Steering Committee of the NDPC.

Tribes have begun to exert a growing influence in the management of diabetes programs. The number of tribally managed programs continues to grow steadily. Eighty one percent of the *Special Diabetes Program for Indians* grant recipients are tribal programs. To responsibly manage a health program requires data that supports an assessment of the health needs of the population. To meet this need, tribal programs were well represented in the IHS 2000 *Diabetes Care and Outcomes Audit* of AI/AN with diagnosed diabetes and will have the opportunity to participate in the 2001 survey. Data gathered by these surveys provides tribes information from which to make rational decisions regarding their diabetes programs.

Best Practices/Industry Benchmarks

The IHS Diabetes Program has a long and distinguished history of serving as a benchmark of diabetes clinical and public health excellence. The IHS developed the *IHS Standards of Care for Diabetes* in 1985, prior to those published by the American Diabetes Association in 1987, and are updated every 2 years based on the latest diabetes science. The IHS has been a leader in developing a diabetes care surveillance system, the *Annual Diabetes Care and Outcomes Audit,* carried out voluntarily in Indian health facilities, to track performance on more than 87 indicators to study trends over time. The *Diabetes Care and Outcomes Audit* monitors use of standards and outcomes of diabetes care, including blood sugar and blood pressure control, screening for complications, and preventive health services such as immunizations and smoking history. In the 1999 IHS *Diabetes Care and Outcomes Audit,* 13,248 charts were reviewed representing care to 80,827 patients at 190 IHS and tribal health facilities in the 12 IHS Areas.

This diabetes care surveillance system has been instrumental in the improvement of diabetes care practices in many Indian health settings. For example, in a special program in Alaska and in northern Minnesota from 1989-93, lower extremity amputation rates were reduced by 50 percent in people with diabetes who received complete foot screening and protective footwear. This same system enabled IHS to measure improvements in blood pressure control in Montana after an intensive intervention in 1993.

Beginning in the late 1970s, the IHS Diabetes Program was a pioneer in developing a public health approach to diabetes. In the early 1980's the program began to publish some of the first national epidemiologic surveillance data regarding the problem of diabetes in AI/AN. The IHS Diabetes Program staff tailored American Diabetes Association education program criteria to fit the unique needs of Indian communities and disseminated the adapted criteria nationally. Later in the 1980s and early 1990's, the IHS began to publish in peer-reviewed journals its experience with using the *Annual Diabetes Care and Outcomes Audit* to measure improvements in diabetes care for Indian communities. A 1994 GAO report outlining diabetes care to elderly Americans was compared to 1995 data from IHS. IHS performed significantly better on all five measures of quality care. In 1998, the IHS Diabetes Program recognized by the Diabetes Quality Improvement Coordinating Committee as one of only two federal agencies who had collected quality improvement data so that it was available for comparison when the Diabetes Quality Improvement Project (DQIP) guidelines were announced. In the January 2001 issue of the medical journal *Diabetes Care* the IHS published an article describing its experience with guidelines and the DQIP measures.

The IHS Diabetes Program has been cited internationally as a model of community involvement and program effectiveness. In 1999 the program was invited to the World Congress on Diabetes Prevention conference to present a description of the Balanced Budget Act of 1997 diabetes grant program. In 2000 the program presented the same information at the 3rd Annual Indigenous People's Conference on Diabetes in New Zealand. As part of its ongoing programmatic activities, the IHS Diabetes Program collaborates with the Centers for Disease Control, the National Institutes of Health, the American Diabetes Association, the National Diabetes Education Program, the American Association of Diabetes Educators, many state Department of Health Diabetes Control Programs, and tribal colleges and universities.

Findings Influencing the FY 2002 Request

The Balanced Budget Act of 1997 *Special Diabetes Program for Indians* (SDPI) provided IHS $30 million per year for 5 years for the prevention and treatment of diabetes. The amendment to the 1997 Balanced Budget Act SDPI through H.R. 4577, the Consolidated Appropriations Act, 2001 provided additional funding for FY 2001, 2002 and 2003. The 1997 BBA funds have provided "seed money" to 318 new programs to begin, or in some cases significantly enhance, diabetes prevention programs in Indian communities. Many of these programs, the majority of which are tribally run, are creating innovative, culturally appropriate strategies to address diabetes. The SDPI funds have enhanced diabetes care and education in AI/AN communities. In FY 2002, some of the funds will be targeted to additional trained personnel, support, technical assistance. The additional funds received from BIPA will enable IHS to implement these grants programs and complicated monitoring and evaluative activities of diabetes prevention and treatment efforts at an increased level.

The Consolidated Appropriations Act of 2001 provides an additional $70 million in new diabetes funding to the IHS for year 2001 and 2002, and then $100 million in Year 2003. The IHS is currently conducting a nationwide tribal consultation process on this new funding. Plans are to provide grants to strengthen clinical diabetes and complications prevention programs and/or to develop and strengthen primary diabetes prevention programs. Whenever possible, the IHS Diabetes Program will strengthen the IHS diabetes

infrastructure at the Headquarters and Area office levels to maintain and improve diabetes surveillance, technical assistance, provider networks and clinical monitoring. Support for the Area Diabetes Consultants, who serve a crucial role in coordinating these functions at the Area level, must be strengthened. In addition, a role for Community Diabetes Advocates will be developed and expanded to coordinate community-based activities to obtain qualitative data and support prevention and treatment programs that are culturally sensitive and focused.

The next challenge for IHS on a national level will be to disseminate the new ideas learned in these grant site settings to other tribal communities for adaptation and implementation.

ACCOMPLISHMENTS

Results of the 1999 IHS-wide *IHS Diabetes Care and Outcomes Audit* to assess diabetes care and education for over 80,000 diabetes patients completed in 1999 revealed an important finding. Data comparisons with 1994-97 results showed a statistically significant improvement trend in blood sugar control among AI/ANs with diagnosed diabetes. This encourging trend has occurred through improved management of diabetes retreats rather than the purchase of newer diabetes medication and equipment. The IHS National Diabetes Program attributes this trend to the extensive commitment that IHS and local communities have made to improve diabetes control. Blood sugar control has been definitively shown in large clinical trials to reduce the complications of diabetes over time and to save money.

Publications documenting our ability to improve care with low tech, low cost approaches have been numerous, even though the costs of providing diabetes care are high. Estimates from managed care organizations suggest that the average cost of diabetes care is $5000-9000 per patient per year, much of this a result of the costs of pharmaceuticals. The IHS per capita expenditure is $1,578. Resources for diabetes care in the Indian health system have mostly been devoted to the clinical care of diabetes and prevention of its complications, rather than to less well scientifically proven methods for primary prevention of diabetes in those without the disease.

Despite these advances, AI/ANs continue to have substantially higher rates of diabetes and its complications than the U.S. population at large.

Specific accomplishments include:

- The IHS National Diabetes Program works closely on diabetes-related issues with tribal leaders through the Tribal Leaders Diabetes Committee. This committee was established by Dr Trujillo to advise the agency on an ongoing basis.

    - The IHS National Diabetes Program staff play significant roles on numerous national diabetes activities:

        ✓ The Director serves as a Steering Committee member on the National Diabetes Education Program; as a member of the Translational Advisory Committee of the CDC Division of Diabetes; as an ad hoc member of the Congressionally-mandated Diabetes Research Working

Group of the NIDDK/NIH; and as a member of the Federal Diabetes Interagency Coordinating Committee.

- ✓ Other staff serves on the National Board of the American Diabetes Association and the Task Force to Review the National Diabetes Education Standards for Diabetes Self-Management.

- The IHS National Diabetes Program initiated an Indian health task force to revise and develop a framework for integrating Diabetes Education Standards for AI/AN communities. The task force will develop a process for achieving formal recognition of quality programs in preparation for HCFA reimbursement of diabetes education.

- The IHS National Diabetes Program and the CDC Division of Diabetes collaborate closely. The IHS Diabetes Program prevalence and complications surveillance system have been automated through the assignment of a CDC Epidemiologist to the program. The prevalence data have been disseminated to the Tribal Leaders Diabetes Workgroup, Area Directors, Area Diabetes Consultants, and others. The data are now available by region on our website.

- A Workgroup has been established with CDC, IHS, the American Academy of Pediatrics and the American Diabetes Association to address the growing concern about type 2-diabetes in Native American children. IHS staff is leading the effort with requests for screening protocols, standards of care and treatment recommendations from these expert groups.

- The IHS established an obesity prevention initiative in 1998 to address the increasing trend of obesity in children ages 3-5 years of age. In partnership with other federal agencies, states and Tribes, the IHS Diabetes Program developed a comprehensive plan for a four-year initiative. Five pilot sites have recently been selected to implement obesity prevention interventions in tribal Head Start programs and communities.

- The IHS National Diabetes Program partnered with the National Indian Council on Aging (NICOA) to develop a pilot project to automate diabetes clinical data at the local and national levels. Eight sites are fully functional.

- The IHS National Diabetes Program collaborated with Macro International, INC, a consultant firm specializing in mixed methods evaluation, to develop an evaluation strategy for the SDPI grants program in 1999. These data served as a major portion of the analysis in the Year 2000 Interim Report to Congress. Data are currently being collected for a revised year 2001 evaluation report.

PERFORMANCE MEASURES

The performance measures associated with this budget request are under development and will be available in mid-July.

Following are the funding levels for the *Special Diabetes Program for Indians* for the last 5 fiscal years:

Year	Funding	
1997	$0	
1998	$30,000,000	
1999	$30,000,000	
2000	$30,000,000	
2001	$100,000,000	Enacted

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ACTIVITY/MECHANISMS BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
INFORMATION TECHNOLOGY INFRASTRUCTURE

Program Authorization:
Program authorized by 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001, and P.L. 102-573, Title II, Section 214.

	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$35,750,000	$42,750,000	$46,985,000	+$11,235,000	+$4,235,000

PURPOSE AND METHOD OF OPERATION

The following summarizes the Information Technology (IT) infrastructure environment highlighting public health information systems, the telecommunications network, and data management capabilities within the IHS.

Current I/T/U Information Systems Environment

The Resource and Patient Management System (RPMS) is a decentralized automated information system consisting of over 60 integrated software applications. The system is designed to operate on micro and mini-computers located at over 400 IHS, tribal, urban Indian health and public health nursing sites/facilities. RPMS software modules fall into three major categories: patient-based administrative applications, patient-based clinical applications, and financial and administrative applications. The patient-based administrative applications include software that performs patient registration, scheduling, billing, and interface functions. The patient-based clinical applications include packages that support the various health care programs including immunization, laboratory, pharmacy, radiology, and diabetes. Thirdly, the financial and administrative applications include application packages that keep track of finances, billing, and equipment inventory/repair. The Division of Information Resources (DIR) develops and tests new software and then distributes the RPMS application suite to IHS Headquarters, each Area Office and other federal partners. Each Area Office releases the RPMS application suite to the appropriate hospitals, clinics, health aid, and State public health nursing sites. Each site may load the full suite of applications or only a subset of the applications (as determined by the size and function of that location). The RPMS applications are highly integrated. This allows the RPMS to store patient data in a core set of centralized files rather than in a number of discipline-specific or program-specific files. This structure allows core data, such as patient visit data, to flow to the necessary software applications without having the system access multiple files or requiring duplicate data entry. Based on this single database structure, RPMS has a set of IHS/Department of Veterans Affairs (VA) tables that are shared by all applications. Sets of data files are shared by related groups of applications as appropriate.

The IHS DIR maintains a centralized data warehouse for patient encounter and

administrative data. Through the wide-area network (WAN) each health care facility feeds select information about patient encounters to the national data repository. The national database is used to provide reports for statistical purposes; performance measurement for GPRA and accreditation; public health and epidemiological studies; third party revenue generation; national equipment inventories; and support for development of the IHS budget process.

The IHS telecommunications infrastructure connects IHS, tribal, and urban (I/T/U) facilities together and to the national data repository. This infrastructure is used for data transmission, voice traffic, and Intranet/Internet access. The capacity to support data transmission as well as new telehealth applications varies greatly and the need exists to upgrade the capacity overall.

The IHS currently uses separate systems for billing, materiel management, financial and personnel management. Since these systems are not integrated, actuarial and cost accounting data is not a reality within the IHS for revenue generation, cost containment, work efficiencies and benchmarking comparisons.

For over fifteen years the IHS has had collaboration with the Department of Veterans Affairs in the development of software and sharing of resources. Recently, this federal health care collaboration has included both VA and Department of Defense on the Government Computer-based Patient Record (GCPR) Framework project. The FY 2002 proposed increase would rollout major improvements in hardware, software, telecommunications and support to rural sites. This step of a multi-year plan would enable the IHS to continue the upgrade of critical components of the information technology infrastructure.

Following are the funding levels for the last 3 fiscal years:

Year	Funding	
1999	$25,750,000	
2000	$35,750,000	
2001	$42,750,000	Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $46,985,000 is a net increase of $4,235,000 over the FY 2001 enacted level of $42,750,000 for information technology infrastructure costs necessary to improve data quality. The net increase is essential to accomplish multiple goals including program accountability and operations, to improve public health surveillance, and to increase third party collections. The net increase includes the following:

Built-in Increases - +$235,000

The request of $235,000 for Federal personnel related cost would fund the built-in increases associated with on-going operations. Included are the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

IHS continues to strive to increase access to the IHS patient population. It is extremely critical that the IHS maintains the FY 2001 level of service to

prevent any further decline in primary health services. Maintaining the current I/T/U health systems is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Information Technology Infrastructure - +$4,000,000

RPMS Upgrades and Interfaces: +$2,000,000

In addition to upgrading software required to improve the RPMS infrastructure, specific emphasis will be placed upon data quality, billing and accounts receivable packages, as well as clinical support components. Upgrading data set exports will include the Patient Statistical Record, ORYX and GPRA measures. These upgrades will provide the ability to extract clinical and financial data to determine best practices. This includes improved security features regarding patient confidentiality, electronic data transmission, and executive and clinical decision making tools for management engineering, bench marking, and best practice measurement (as required by GPRA, HIPAA, OMB, etc.). The enhancements will improve the capability to interface internal and external data systems with the RPMS to improve the validity and completeness of national databases. These investments will pay off with improved I/T/U clinical care, performance measurement, cash flow and work efficiencies. This will provide 24 hour, seven-day-a-week national and area support to I/T/U facilities. It will provide significant improvements in RPMS user training through on-site instructor led courses, web-based training and correspondence courses. It will also provide information technology professional training through national on-site instructor lead courses, Commercial-Off-The-Shelf (COTS) vendor courses and self-paced instruction.

Telecommunications Infrastructure Improvement: +$1,000,000

Upgrades to telecommunication infrastructure to meet the needs of both urban and rural healthcare programs dependent upon the transmission of voice, data, or images (e.g., x-rays) between smaller, primary care health facilities and larger referral medical centers. The infrastructure would provide a secure environment and allow sufficient bandwidth for the potential benefit of advancing telemedicine and teleradiology programs. Improvements target support for hardware, software, and staffing to more effectively utilize available technologies.

Data Collection, Analysis, and Quality Improvements: +$1,000,000

Upgrade hardware and purchase software to increase the ability of all internal and external customers to extract demographic, clinical, financial, and epidemiologically significant trends in a secure environment. This project combined with the RPMS upgrade and telecommunications improvements will improve data quality and will satisfy the multiple goals of program accountability, improved public health surveillance, and increased third party collections.

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ACTIVITY/MECHANISMS BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service - 75-0390-0-1-551
EPIDEMIOLOGY CENTERS

Program Authorization:
Program authorized by 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001, and P.L. 102-573, Title II, Section 214.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$950,000	$1,450,000	$1,450,000	+$500,000	0

PURPOSE AND METHOD OF OPERATION

Although acquisition of medical data through development of information systems is critical, just as important is the ability to analyze and interpret the data. Because most medical data are complex, simple reports automatically generated by computer systems cannot answer many questions posed by health professionals and administrators. Trained epidemiologists are needed to complete the system of health information for tribes and communities.

The innovative Tribal Epidemiology Center program was authorized by Congress as a way to provide significant support to multiple tribes in each of the IHS Areas. Beginning in FY 1996, four Centers were funded up to $155,000 each. Since then, these centers have proven that the concept is sound and worthy of additional funding and expansion of the program. In response to a Request For Proposal in FY 2000, the four original centers were funded for another five years, and two new centers were funded. The annual level of funding for FY 2001 will be approximately $207,000 for each center. This primary source of increased funding was a $500,000 increase in FY 2001 earmarked for HIV research.

Operating from within tribal organizations such as regional health boards, the Epidemiology centers are uniquely positioned to be effective in disease surveillance and control programs, and also in assessing the effectiveness of public health programs. In addition, they can fill gaps in data needed for Government Performance Results Act and Healthy People 2010. Some of the four existing Epidemiology Centers have already developed innovative strategies to monitor the health status of tribes, including development of tribal health registries, and use of sophisticated record linkage computer software to correct existing state data sets for racial misclassification. These data may then be collected by the National Coordinating Center at the IHS Epidemiology Program to provide a more accurate national picture of Indian Health.